CDPHP Prior Authorization / Medical Exception Request Form

Fax or mail this form back to:
CDPHP Pharmacy Department, 500 Patroon Creek Blvd., Albany, New York 12206-1057
Phone: (518) 641-3784 Fax: (518) 641-3208

Patient Information:

Last Name:_________________________ First Name:_________________________

Member ID #: _________________________ Date of Birth:_________________________

Please check one: Medicare __ Select Plan (Medicaid)/Family Health Plus __ Other Plan Type __

Pharmacy & Phone (if known): _________________________

Drug Information:

Drug Requested: _________________________ Strength: _________________________

Dosing Regimen: _________________________

Questions:

1. Has the patient previously received this drug? Yes_____ No _____
   How long has the patient been on this drug? _____________________
2. If this patient had a documented allergy/adverse reaction on formulary medications, describe:_________________________
   ____
3. Document prior therapy trials and failures. (Include details of dose and duration of therapy)
   ____
   ____
   ____
4. Patient Diagnosis: _________________________
   Diagnosis Code (required): ___________________
5. Describe patient-specific medical rationale:_________________________
   ____
   ____
   ____

Practitioner Information:

Practitioner Name: _________________________ Practitioner Phone # ___________________

Address:_________________________ Fax (for notification):___________________

Nurse Contact: _________________________ Ext._____ Date: _________________________

CDPHP reserves the right to review and audit charts as defined in the Participating Physician Agreement, Section 12.3.