



## **IMPORTANT ANNOUNCEMENT**

Please read carefully and  
keep this letter for your records

## **Please start using the attached form now.**

Please note that effective January 1, 2015, the California Department of Managed Healthcare (DMHC) under Title 28, California Code of Regulations, Section 1300.67.241, requires prescribers to use pharmacy prior authorization (PA) Form No. 61-211 for all non-Medicare health plans. Subsequent to California Senate Bill (SB) 282, updates to Form 61-211 were made in December, 2017. The updated PA form is attached below.

**\*\*Prior authorization requests submitted on other forms will not be accepted\*\***

### **Fillable New Prior Authorization Forms**

Prior Authorization Form No. 61-211 are located at these websites in convenient PDF format:

- [http://cchealth.org/healthplan/pdf/performrx\\_medication\\_prior\\_auth\\_form.pdf](http://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf)
- <http://tinyurl.com/cchprxpform>
- Please fax the completed form to PerformRx at 1-866-205-8014 (standard) or 1-866-428-7369 (urgent) or Contra Costa Health Plan at 1-925-313-6412 (urgent).
- You may also call 1-925-957-7260, option 2 to have this form faxed to you. Business hours are 8am–5pm Pacific, M-F.

### **Online Prior Authorization Submission URLs**

You may submit a prior authorization request online through PerformRx's web submission form:

- <http://cchealth.org/healthplan/pdl.php> then click on the "PA Form Online" link.
- <http://tinyurl.com/ppaonline>

### **Telephone Prior Authorization Submission**

You may phone in prior authorization requests at 1-877-234-4269, option 2. The hours of business are 8am–5pm Pacific, M-F.

### **Please fax the following completed form to the number below:**

**Contra Costa Health Plan (BIN 600428, PCN 03970000)**

**Pharmacy Prior Authorization Fax:**

**1-866-205-8014 (standard)**

**1-866-428-7369 (urgent)**

**1-925-313-6412 (urgent)**

### **Need assistance?**

Please speak to a CCHP Pharmacy Authorization Representative at 1-925-957-7260, option 2, 8am–5pm Pacific, M-F.

## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: \_\_\_\_\_ Plan/Medical Group Phone#: (\_\_\_\_\_) \_\_\_\_\_  
 Plan/Medical Group Fax#: (\_\_\_\_\_) \_\_\_\_\_ Non-Urgent  Exigent Circumstances

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

### Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:		City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

### Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

### Prescriber Information

First Name:	Last Name:	Specialty:
Address:		City: State: Zip Code:
Requestor (if different than prescriber):		Office Contact Person:
NPI Number (individual):		Phone Number:
DEA Number (if required):		Fax Number (in HIPAA compliant area):
Email Address:		

### Medication / Medical and Dispensing Information

Medication Name:			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____			
How did the patient receive the medication?			
<input type="checkbox"/> Paid under Insurance    Name: _____		Prior Auth Number (if known): _____	
<input type="checkbox"/> Other (explain): _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration:			
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____			
Administration Location:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care	

## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:
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**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

<b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>Medication/Therapy</b> (Specify Drug Name and Dosage)	<b>Duration of Therapy</b> (Specify Dates)	<b>Response/Reason for Failure/Allergy</b>
<b>2. List Diagnoses:</b>		<b>ICD-10:</b>
<b>3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.</b>		
<p>Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.</p> <p><input type="checkbox"/> Attachments</p>		

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**Plan/Insurer Use Only:**    Date/Time Request Received by Plan/Insurer: \_\_\_\_\_    Date/Time of Decision: \_\_\_\_\_

Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Approved     Denied    Comments/Information Requested: \_\_\_\_\_