



News Flash!

A FAX Publication for Providers of Sharp Health Plan

To: Sharp Health Plan Physicians and Office Staff
From: Sharp Health Plan Health Services Department
Date: November 21, 2014
Subject: New Prescription Drug Prior Authorization Request Form (61-211)

*****Effective: January 1, 2015*****

A new law, Senate Bill-866 (SB866), is intended to streamline the process and standardize the requirements for prescription drug prior authorization across the industry. The law requires all insurers, health plans and their contracting medical groups/IPAs to use the new two-page Form 61-211 for prescription drug prior authorization. Effective January 1, 2015 Sharp Health Plan (SHP) and our Plan Medical Groups (PMGs) will be required to accept only the attached Prescription Drug Prior Authorization Request Form for all Prior Authorization (PA) requests for prescription drugs processed through the outpatient prescription drug benefit and prescription medications processed under the medical benefit.

Specific Provisions of the Law:

- Mandates the use of Form 61-211 for all PA requests for prescription drugs
- Reduces the turn-around-time for determination of prescription drug PA requests to 2 business days
- PA requests that are not approved or denied within 2 business days of receipt by the Plan/PMG shall be deemed “approved”
- Requires rejection of PA requests submitted on forms other than the new Form 61-211
- Require only the minimum amount of material information necessary to approve or deny a PA request
- A denial for lack of medical necessity must contain an accurate and clear written explanation of the specific reason(s) for denial
- PA requests containing insufficient medical information necessary to make a determination may **NOT** be pended for additional information
- A denial for lack of information necessary to make a determination must contain an accurate and clear written explanation of the specific material information that is necessary to approve the request

The Law Does Not Change:

- **The drugs requiring prior authorization by SHP or your PMGs**
 - Applies to Prescription Drug requests submitted to SHP for Pharmacy Prior Authorization
 - Applies to Prescription Drugs processed under the Medical Benefit submitted to SHP or your PMG (injectables/home infusion etc.), per the current process
- **The process and/or fax numbers for PA submission**
 - Continue to submit Pharmacy Benefit PA requests to SHP: fax 858-357-2534
 - Continue to submit Medical Benefit PA requests through PMG or SHP under current Utilization Management processes

The New Form is Available:

- On the Provider page of www.SharpHealthPlan.com under the forms tab
- In the SharpConnect Provider Portal, under the Consumer Resources
- In ACES under References

For Your Convenience we have included a Fax Cover Page-This is not an official part of Form 61-211



IMPORTANT ANNOUNCEMENT

**New regulations require changes to the
Prescription Drug Prior Authorization Form**

**You may start using the attached form now.
You will be required to use this form January 1, 2015**

Please note: 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 Form No.61-211 for non-Medicare health plans. This form is attached below.

After January 1, 2015

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

The Law Does Not Change:

- **The drugs requiring prior authorization by Sharp Health Plan (SHP) or our Plan Medical Groups (PMGs)**
 - Applies to Prescription Drugs submitted for Pharmacy Prior Authorization to SHP
 - Applies to Prescription Drugs processed through the Medical Benefit submitted to SHP or your PMG (injectables/home infusion etc.)
- **The process and/or fax numbers for PA submission**
 - Continue to Fax Pharmacy Benefit PA Requests to SHP Fax number below
 - Continue to Fax Medical Benefit PA Requests to SHP or your PMG

The Form is Available:

- On the Provider page of www.SharpHealthPlan.com under the forms tab
- In the SharpConnect Provider Portal, under the Consumer Resources
- In ACES under References

Please fax the following completed form to the number below:

**Sharp Health Plan
Pharmacy Prior Authorization
FAX: 1-858-357-2534**

Need assistance?

**Please speak to a Customer Care Representative at 1-858-359-2002
Monday - Friday 8am - 6pm**

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ Plan/Medical Group Phone#: (_____) _____
 Plan/Medical Group Fax#: (_____) _____

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 request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

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 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 REQUEST FORM

Patient Name:

ID#:

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 request.

1. Has the patient tried any other medications for this condition? ☐ YES (if yes, complete below) ☐ NO

Medication/Therapy
(Specify Drug Name and Dosage)

Duration of Therapy
(Specify Dates)

Response/Reason for Failure/Allergy

2. List Diagnoses:

ICD-9/ICD-10:

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

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 (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

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: _____ **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 Use Only: Date of Decision: _____

☐ Approved ☐ Denied Comments/Information Requested: _____