Prior Authorization (PA) Request or Formulary Exception Form

PO Box 91110
Sioux Falls, SD 57109-1110
Toll-Free: 1-877-492-5189
(TTY 711)
Fax: 1-701-234-4568

Great Plains Medicare Advantage

INSTRUCTIONS:

1. Only request one (1) medication per form.
2. All fields must be completed and legible for review.
3. **The Plan's decision will be based on individual plan policy and clinical documentation submitted.**
4. Submit online through your provider portal at sanfordhealthplan.com/providerlogin. **Prior authorizations *cannot* be completed over the phone.**
5. Questions? Contact Pharmacy Management Department at 1-877-492-5189.

Please check the appropriate box below. This form is being used for:

☐ Formulary Exception ☐ Prior Authorization (PA) Request ☐ Unsure/Unknown

Member Information

Member Name:	Date of Birth:
Member ID #:	Drug Allergies:

Provider Information

Prescriber name (first & last):	☐ MD ☐ NP ☐ DO ☐ APRN ☐ PA ☐ _____
Specialty: NPI #:	
Address:	
City, State, Zip:	
Phone: Fax:	
Contact person at provider's office:	

Billing Facility Information *(if applicable)*

Facility Name:	
Tax ID #: NPI #:	
Address:	
City, State, Zip:	
Phone: Fax:	
Contact person at facility:	

Prescription Drug Information

Medication being requested:	Strength:	Quantity:	Day's Supply:
HCPC (if applicable):	Directions for use:		

Requested therapy medication is: ☐ New ☐ Continuation of therapy ** If continuation, provide start date: _____	Expected length of therapy:	☐ Check here if this request is for retroactive coverage for a previous claim or date of service. Date of service: _____

Medical rationale for use:

Diagnosis

PRIMARY DIAGNOSIS (ICD-10 CODE):	SECONDARY DIAGNOSIS (ICD-10 CODE):
DESCRIPTION:	DESCRIPTION:

Clinical Information Submitted for Determination

- The specific records needed for review must be attached. Denote below which pages of the records to review to help expedite the review process.
- If you are a Sanford Health provider and would like the Plan to review clinical documentation in One Chart (the patient's electronic medical record), the dates and descriptions of specific records to reference **must** be indicated below.

☐ Current clinical notes

☐ Labs

☐ Other

☐ Other medical conditions to consider:

☐ If the request is for a formulary exception, explain why the preferred medication(s) would not meet the Member's needs:

Previous Therapies

- List all current and past therapies the Member has tried specific to the diagnosis.
- **NOTE:** "see chart" is not acceptable documentation for this section.

Medications/Therapies (Drug name, strength, & dosing schedule)	Dates of Therapy/ Treatment Duration	Outcome of Therapy or Reason for Discontinuation (Describe any adverse reactions or efficacy failure)

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Signature

Requesting Person/Authorized Representative Signature:

Printed Name: Date Submitted: