HealthNow
HealthNow New York Inc.

PRIOR APPROVAL/NON-FORMULARY MEDICATION REQUEST FORM

Toll Free FAX # 1 (866) 221-5784

Toll Free TELEPHONE 1-800-716-3230

Date: _____/_____/_____

Patient Name: _____

ID#: _____ DOB: _____/_____/_____

Diagnosis: _____

Medication Requested: _____

HNNY USE

Dosage & Regimen Prescribed: _____ Anticipated Duration*: _____

*Maximum duration for approvals is one year, and may be less for acute care or at Plan discretion.

Justification for Request: (Where applicable, please list other medications, allergies or therapeutic measures attempted and results; additional supporting documentation such as lab reports and test results should also be attached):

Medications Tried

_____ _____

_____ _____

_____ _____

_____ _____

Prescribing Physician Name (Please Print): _____

Prescribing Physician Signature: _____

DEA #_____ Provider # _____

Telephone # (_____)_____ **FAX** # (_____)_____

HNNY USE ONLY

_____Pended (Information Needed to Complete Request (Our Decision Is Pending Your Response)):

DATE PENDED REQUEST WILL BE CLOSED: _____/_____/_____

Date: _____/_____/_____ Signature: _____

Determination: _____Denied _____Approved Time Period: _____

Reason:

Date: ____/_____/_____ Signature: _____

Approvals are only valid if person has active prescription drug coverage through HealthNow New York. This prior authorization is subject to all drug therapy guidelines in effect at the time of the approval and other terms, limitations and provisions in the member's contract/rider. We reserve the right to update and/or modify our drug therapy guidelines for prospective services.