Page 1 of 2

Santa Clara
Family Health Plan

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: Santa Clara Family Health Plan
Plan/Medical Group Phone#: (408) 874-1796
Plan/Medical Group Fax#: (408) 874-1444

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: Andrew	Last Name: Sharp	MI:	Phone Number: (650) 906-9448
Address: 212 Thompson Sq	City: Mountain View	State: CA	Zip Code: 940434219
Date of Birth: 12/14/1958	☐ Male ☐ 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: 98862748F
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name: Veko	Last Name: Vahamaki	Specialty: FP	
Address: 701 E EL CAMINO REAL FL 2ND	City: MOUNTAIN VIEW	State: CA	Zip Code: 94040
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual): 1760548945		Phone Number: (650) 404-8370	
DEA Number (if required): BV9195505		Fax Number (in HIPAA compliant area): (650) 404-8436	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name: Vyvanse 50MG Capsules

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name: ____________ Prior Auth Number (if known): ____________
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
50MG			30 per 30 days

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Physician's Office
☐ Ambulatory Infusion Center
☐ Patient's Home
☐ Home Care Agency
☐ Outpatient Hospital Care
☐ Long Term Care
☐ Other (explain): ____________

Page **2** of **2**

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name: Andrew Sharp	ID#: 98862748F

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:** 06/12/2015

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: ______________________