PRIOR AUTHORIZATION REQUEST

Antimalarial Agents

PATIENT:
Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber:
Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: _____
Plaquenil (hydroxychloroquine sulfate)
Aralen (chloroquine phosphate)

Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ☐ Yes ☐ No Is there an approved FDA indication for this medication such as Systemic Lupus, Malaria, or Rheumatoid arthritis?
2. ☐ Yes ☐ No Is this medication being used for treatment or prevention of COVID-19?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____ _____
PHYSICIAN SIGNATURE DATE

SECTION C References:

Drugs.com [Internet]. Hydroxychoroquine/Chorlquinine; Updated: [Jan 7, 2020. Citation: April 7th, 2020]. https://www.drugs.com/ppa/hydroxychloroquine.html#moreResources.

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 800-753-2851