



**Jackson**  
HEALTH SYSTEM

# JMH Health Plan

155 South Miami Avenue, Suite 110  
Miami, Florida 33130

Tel: (305) 575-3642 (For information only) Fax: (305) 355-2589

## Pharmacy - Prior Authorization/Medical Exception Form

**\*\* Please complete all areas in order to process this request \*\***

### I. Patient information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Patient ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
 Line of Business: JMH Commercial: \_\_\_\_\_ JMH Medicaid: \_\_\_\_\_ Flex: \_\_\_\_\_

### II. Physician Information:

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Hospital/Clinic Affiliation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Physician Phone #: \_\_\_\_\_ Physician Fax #: \_\_\_\_\_ Pager: \_\_\_\_\_  
 Nurse/Office Staff: \_\_\_\_\_ Phone # or Extension: \_\_\_\_\_

### III. Medication Information - Please complete questions below:

- Medication Request- include drug, dose, strength, route, frequency, and directions for use.  
 Drug: \_\_\_\_\_ Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_  
 Directions for Use (Sig): \_\_\_\_\_  
 Duration of Use: \_\_\_\_\_ PRN: Y \_\_\_\_\_ N \_\_\_\_\_
  - Diagnosis/Indication for Use: \_\_\_\_\_ ICD-9: \_\_\_\_\_
  - Has patient previously received this drug? Y \_\_\_\_\_ How long? \_\_\_\_\_ No \_\_\_\_\_
  - List therapy failure on previous drugs therapies within the same or similar therapeutic class:  
 \_\_\_\_\_  
 \_\_\_\_\_
  - Justification for Specific Drug- Please provide or attach progress notes, consults, labs, etc as needed:  
 \_\_\_\_\_  
 \_\_\_\_\_
  - Injectable Drugs Only: Patient Self-Administration: \_\_\_\_\_ Office/Clinic Administration: \_\_\_\_\_  
 Home/Office Infusion drug: Y \_\_\_\_\_ N \_\_\_\_\_ Will home health be required: Y \_\_\_\_\_ N \_\_\_\_\_  
 Will home health be required: Y (for teaching) \_\_\_\_\_ Y (for administration) \_\_\_\_\_ N \_\_\_\_\_
- \*Please attach prescription order to this form\***

**\*Injectable (SQ/IM/IV) drugs are coordinated with DOMC pharmacy providers and will be delivered to patient or physician's office as needed.**

### PRIOR AUTHORIZATION/DRUG REQUEST REPLY (DOMC USE ONLY)

\_\_\_\_\_ Additional Information Required: \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Non-Formulary Drug (PA form/PDL page faxed): \_\_\_\_\_  
 \_\_\_\_\_ Approved: One time only \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date: \_\_\_\_\_  
 \_\_\_\_\_ Benefit Exclusion - Drug is not a covered product. Refer to Certificate of Coverage  
 \_\_\_\_\_ Formal Denial (letter sent): \_\_\_\_\_ Date: \_\_\_\_\_