Revised 5/23/2011

Prior Authorization Requirements for medication changes
Prior Authorization (PA) Packet

As you know recent changes in the medical insurance industry have caused each of us to become more aware of the medications that are being prescribed. Your medical insurance company has a drug formulary, which contains a list of covered drugs. Each insurance company may have hundreds of individual formularies it uses for its customers. It is impossible for your physician to know exactly which medications are listed on your particular formulary.

If you desire to initiate a prior authorization request to your insurance company, to change your medication, you can choose the following options. Most of these prior authorizations will be denied by your insurance company, since you have a specific medicine formulary, and their requirements are strict. If your insurance company denies your request, we will fax or mail the response to you.

1) Your easiest and most successful option
   You may call your insurance company and determine what medicine they will cover in your contract in place of the prescribed medication. After you determine this, you may call our office and we will call the medication in to your pharmacy or mail you a new prescription to your home, if needed. This has the greatest chance of success with your insurance company.

2) You may go online to our website www.hwwc.net and download a prior authorization packet which will include instructions. After you complete the forms, they can be faxed or mailed to our office.

   Fax: 205-910-1831
   Mailing address: 806 St Vincent's Drive Suite 500 Birmingham, AL 35205
   (Attention: Prior Authorization Requests)

3) If you do not have internet access, you may call 205-930-1800 and ask for Patient Assistance, and they can either mail or fax you a "PA packet".

Again, we hope that this process is helpful and will aid you in getting your prescriptions filled. We apologize for any inconvenience this may cause however, this is a requirement of your insurance company.

PATIENT QUESTIONAIRE

This questionnaire and the form from your insurance company must be mailed/faxed to us. You are responsible for obtaining the necessary paperwork from your insurance company and sending it to us along with this completed questionnaire. If you experience difficulty getting the necessary paperwork from your insurance company, you may want to call your employer's benefits manager and let them know about the situation. **As a reminder, we must have both of these items if you would like for us to try and get your medication authorized.**

Name_____Date of birth:_____

Ins. Company:_____ID#_____

Subscriber Name_____Group#_____

HWWC Physician:_____

Name of medication being prescribed:_____
Reason the medication is being prescribed:_____
Have you taken any other medications for this same problem?_____

If so, please list the name of the drug, dates of therapy:_____
_____

How long have you been on this medication?_____
When was this medication first prescribed?_____
What is the name of the physician who first prescribed the medication?_____
Did you receive any samples of the medication in the office?_____

List any other information that may be pertinent to this medication request that may be helpful to your insurance company:_____
_____

Do you have a prescription copay?_____ Amount:_____

I, _____ hereby certify that the above information is
Patient name

Accurate and complete to the best of my knowledge.

_____ _____
Patient's signature Date