Bluegrass Family Health

Medication Pre-Certification Request for: **POST ACUTE WITHDRAWL AGENTS**

Phone: 877-205-6308

Fax: 859-335-3744

Instructions: This form is to be used by participating physicians and providers to request approval for medications requiring a PA. Approval is based on medical necessity criteria established by the Bluegrass Family Health's Pharmacy and Therapeutics Committee. Please complete this form in detail and fax to 859-335-3744. **Requests lacking pertinent information will be denied pending additional information. For this reason, office notes may be required.**

MEMBER INFO:

Name: ______________________ ID Number: ________________ DOB: __________

Diagnosis and Code: ____

Drug Requested: ______________ Strength ________________ **JCODE** _______

Length of Treatment: ________ Quantity: ________ Dosage Form: Oral / Injection / Topical

Is the patient actively participating in a comprehensive management program that includes psychosocial support? ____

Timeframe Patient has been Opiod-Free: _____________ Alcohol Free: _____________

Medication History including medications tried and failed (please include strength and dose of each): ____

Other Pertinent History, including liver failure/hepatitis: __________________________

PROVIDER INFO:

Will the doctor be providing this medication? YES / NO

Will this be administered at the provider office? YES / NO

Physician Name and Specialty: ____

DEA# _____________ Contact Person (Please Print): _________________________

Telephone Number ____________________ Fax Number ____________________

Signature of Contact Person: ____

BFH USE ONLY:

Request was: Approved Qty approved: _______ Denied Pending More Info

Specialist Initials: ______ Start Date: ______________ Expiration Date: __________

Comments: ____

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