WASHTENAW HEALTH PLAN
REQUEST FOR PRIOR AUTHORIZATION
(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

REQUESTING PHYSICIAN:

Name
Direct Phone #
Fax #:
Physician Specialty

MEMBER INFORMATION:

Name
WHP ID#
Date of Birth
Gender: ☐ Female ☐ Male

_____
Name and title of person completing form (please print)

MEDICATION	STRENGTH	DOSES PER DAY	LENGTH OF THERAPY
Indication/Diagnosis for requested medication		Past medical history, allergies or other pertinent medical information, that necessitates the use of this medication:	
Rationale for use of requested medication over formulary options			

Previous WHP formulary medications tried and failed for this condition (name and strength of medication)	Dates of treatment	Reason for failure (outcomes, lab values, adverse effects, etc.)
1.		
2.		
3.		
4.		

Other Supporting Information *(use additional pages if necessary):*

<u>Fax Requests to</u>: Ingham Health Plan Corporation, Fax: (517) 394-4590
For more information, phone: (866) 291-8691

COMMENTS: