



FAX 1-888-239-4484

**Health Choice Generations Medicare Advantage  
Special Needs Plan Behavioral Health Medication  
PRIOR AUTHORIZATION FORM**

Member Name \_\_\_\_\_  
Date of birth \_\_\_\_\_  
HC Generations ID# \_\_\_\_\_

The HCG providers should submit some form of standardized symptom assessment to establish proper diagnosis and to monitor response to treatment. (e.g. Beck, Hamilton's, Connor's).  
**NOTE:** Dual-eligible members with HCG Medicare Advantage AND HCA (AHCCCS) may have no medication co-payments on behavioral health medications prescribed by the contacted RBHA.

**1. Has the member previously received Behavioral Health treatment from another provider?**    No    Yes

**If YES, the following information should be included with a standardized assessment questionnaire:** Diagnoses, provider name and specialty (e.g. psych, PCP), date/s of service, and any behavioral health hospitalizations or outpatient programs if applicable.

**2. All previously tried psychiatric medications (from current and past prescriber/s) must be provided with documentation of duration of use and reason cited for medication failure.**

**3.  The PCP/provider OR  The RBHA will continue to monitor psych med management (mark one), or**

A referral to RBHA with bridge medication request

PCP/provider office will complete RBHA referral

Request referral assistance from Health Choice

Diagnosis/ICD-9code \_\_\_\_\_ / \_\_\_\_\_

Diagnosis/ICD-9code \_\_\_\_\_ / \_\_\_\_\_

Date: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_

PCP (If different) \_\_\_\_\_

Office Contact:  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

To Request Non Formulary med or to exceed maximum dose/quant. limitations:

Name of Med: \_\_\_\_\_

Dosage/Sig: \_\_\_\_\_

Quantity: \_\_\_\_\_ Refills \_\_\_\_\_

**Part D Medication Request Determination**      **ALL OTHER Medical Service Requests**  
Mark One:  Standard (< 72 hrs)    Expedited (< 24 hrs)   **///**    Standard (<14 days)    Expedited (<72 hrs)

**Providers must use Expedited only when medically necessary!** Inappropriate use of An Expedited request is not acceptable and can delay timely attention to true Expedited requests.  
**Inappropriate Expedited requests may be down graded to Standard by HCG.**

Response to Provider: Health Choice has considered the above request and has made the following determination:

Approved

Denied For the Following Reason(s):

- No notes were received with the request by HCG in order to evaluate for medical necessity.
- No documentation of medical necessity based on information received by HCG.
- No documentation of trial/failure of conservative medical treatment by the referring provider.
- No documentation of trial and/or failure of formulary medications OR a need to exceed plan limits.
- Formulary choices/other choices in this class/for this diagnosis are available without prior authorization.
- The preferred prior auth formulary choice was not requested.

Denial letter type: \_\_\_\_\_

Medical Director Sig: \_\_\_\_\_ Date of Decision: \_\_\_\_\_

**\*\*\*PROVIDERS MUST FILL OUT FORM COMPLETELY AND SEND MEDICAL DOCUMENTATION WHICH SUPPORT THE REQUESTED SERVICE. FAILURE TO DO SO MAY RESULT IN A DENIAL OF SERVICE\*\*\***