Updated: 04/2020
DMMA Approved: 04/2020

Request for Prior Authorization for COVID-19
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for brand or generic Plaquenil (hydroxychloroquine) and Aralen (chloroquine) require a prior authorization and a diagnosis to be entered at the point of sale.

Covid-19 Prior Authorization Criteria:

Claims will pay at the point of sale for a maximum of a 34 day supply or 100 units (whichever is greater) when at least one of the following is met:

- A member has a paid claim for the requested medication within the previous 120 days.
- The member has an FDA-approved diagnosis and it was entered at the point of sale.
    - FDA approved indications include the following:
        - Lupus (H01.12*, L93*, M32*)
        - Rheumatoid Arthritis (M05*, M06*)
        - Malaria (B50*, B51*, B52*, B53* B54*)

    *(*) indicates all of the subtypes under that listed code (e.g., M05.1 and M05.2, etc.) are included.*

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

Highmark Delaware HEALTH OPTIONS

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COVID-19
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____ ICD-10 Code: _____

Requested medication: ☐ hydroxychloroquine ☐ chloroquine

Quantity requested : _____ Expected duration of treatment: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date