Please allow 72 hours for request to be completed. Call 303-602-2070 or 877-357-0963 with questions.
After all portions are complete, fax to: 303-602-2081 or submit via email to: ManagedCarePAR@dhha.org
All areas MUST BE COMPLETED in order to process this request form. Please print legibly.

Prior Authorization Request (PAR)-DH Managed Care

Patient Information (May be completed by pharmacy staff if applicable)		Date Initiated:
Last:	First:	
DH Medical Record #:		
DOB:	Sex: ☐ **M** ☐ **F**	Phone Number:
☐ **DHHA** ☐ **CSA/DERP** ☐ **DPPA** ☐ **DPS** ☐ **CHP+** ☐ **DH Medicaid** ☐ **DH Medicare** ☐ **Elevate**		
Insurance #:		
Drug Requested:	Strength:	Qty:
Rx Directions (sig):		
Comments:		
Prescriber:	**DH Staff Provider?** ☐ **Yes** ☐ **No**	Clinic Fax #
To be filled at: ☐ Webb Pharmacy ☐ Central Fill (mail order) ☐ Eastside ☐ La Casa Pharmacy ☐ Westwood ☐ Montbello ☐ Park Hill ☐ Lowry ☐ Westside Pharmacy ☐ Public Health Pharmacy ☐ DH Discharge Pharmacy ☐ Pena ☐ Other _____		

Clinic Portion (May be completed by Provider or other designated individual)		
☐ **New Request** ☐☐☐ ☐ **Renewal Request** ☐ **Urgent (Life Sustaining Only) ****		
☐ **Attending** ☐ **Fellow** ☐ **Resident**	Pager:	Clinic Name:
Contact Person:	Phone:	Fax:
Completed By (if different):	Email address (if non-DH):	
PATIENT DIAGNOSIS:		
How long will pt be on this med?		
Will Drug Need to Be Titrated? ☐ Yes ☐ No	If yes, what doses?	
Medical Rationale/ Necessity - May provide clinical documentation for medical necessity (i.e. encounters, lab, radiology, etc.):		
Is the patient currently receiving this drug? ☐ Yes ☐ No If yes, greater than 3 mos? ☐ Yes ☐ No		
Please list all other medications the patient has tried for this diagnosis and duration of use.		

Behavioral Health Management – If Applicable (May be completed by Provider or other designated individual)	
Case Manager:	Phone:
Medication monitoring: Yes ☐ No ☐	Prescription Coordinated through DH Pharmacies: Yes ☐ No ☐

For DHMP Medical Services Use Only **Please Do Not Write Below This Line**		
Approved ☐	**Denied** ☐	**Withdrawn (fax back to Pharmacy and Provider)** ☐
Comments:		

Signature: _____ **Date:** ____/____/____ **Rx Begin Date:** ____/____/____ **End Date:** ____/____/____
Managed Care Authorization Signature

For after-hours **urgent requests, please call the MedImpact help desk at 800-788-2949