Medicaid Managed Care
Florida Healthy Kids

Prior Authorization Form for Medical Injectables

This communication applies to the Medicaid programs for Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) as well as the Florida Healthy Kids (FHK) program for Simply.

This prior authorization (PA) form and PA criteria may be found on our provider websites at **https://provider.simplyhealthcareplans.com** and **https://provider.clearhealthalliance.com**. If the following information is not complete, correct, and/or legible, the PA process can be delayed. Please use one form per member. Please allow Simply and CHA at least 24 hours to review this request. If you have telephone requests or questions, please call **844-405-4296**. Fax this completed form to **844-509-9862**.

Member information

Last name	First name	MI	Member ID	Date of birth	Sex (select one) ☐ Male ☐ Female
Member's place of residence: ☐ Home ☐ Nursing facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Height		Weight

Requesting prescriber information

Last name	First name	MI	NPI (required)	DEA/license
Address where service was rendered			City	
State	ZIP code	Telephone number ( )		Fax number ( )
Office contact name				Contact direct phone number ( )

Administering prescriber information

Name			NPI/tax ID (required)	DEA/license
Address where service was rendered			City	
State	ZIP code	Telephone number ( )		Fax number ( )
Office contact name				

Billing facility information

Name	NPI/tax ID (required)	DEA/license

Address		City	
State	ZIP code	Telephone number ( )	Fax number ( )
Office contact name			

Medication information

Drug name and strength requested:	SIG: (dose, frequency and duration)	HCPCS billing code
Diagnosis and/or indication:		ICD-10 code (required):

Has the member tried other medications to treat this condition? ☐ **Yes**, provide this information in the area to the right. You may be asked to provide supporting documentation such as: • Copies of medical records. • Office notes. • A completed *FDA Medwatch Form*. ☐ **No**, explain why not:	Drug name(s) and strength:	
	Date range of use:	Sig code: (dose and frequency)
	Did the member experience any of the below? ☐ Adverse reaction ☐ Inadequate response ☐ Other Briefly describe details of adverse reaction, inadequate response or other in the space provided below.	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:

List all current medications including dose and frequency:

Other pertinent information:

Diagnostic studies and/or laboratory tests performed (List all tests done within the past 30 days that are related to diagnosis of medication requested.)

Labs			**Diagnostic tests**		
Test	Date	Result	Procedure	Date	Result

Signature

Prescriber's signature (required) Date

By signing, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission, or concealment of material may be subject to civil or criminal liability.