Please allow 72 hours for request to be completed.

Please fax completed form to: 720-956-2303 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

<table>
<tr><td colspan="6">Patient Information (May be completed by pharmacy staff if applicable)</td></tr>
<tr><td colspan="4">Last:</td><td colspan="2">First:</td></tr>
<tr><td colspan="6">DH Medical Record #:</td></tr>
<tr><td>DOB:</td><td colspan="2">Sex: M F</td><td colspan="3">Phone Number:</td></tr>
<tr><td colspan="6">DHMP DHMP POS CHP+ DH Medicaid Choice DH Medicare Choice DH Medicare Select DERP/CSA</td></tr>
<tr><td colspan="2">Insurance #:</td><td colspan="4"></td></tr>
<tr><td colspan="2">Drug Requested:</td><td colspan="3">Strength:</td><td>Qty:</td></tr>
<tr><td colspan="6">Rx Directions (sig):</td></tr>
<tr><td colspan="6">Comments:</td></tr>
<tr><td colspan="2">Prescriber:</td><td colspan="3">DH Staff Provider? Yes No</td><td>Date Initiated:</td></tr>
<tr><td colspan="6">To be filled at: DH 1° Care Pharmacy Central Fill (mail order) Eastside Pharmacy La Casa Pharmacy Westside Pharmacy ID/AIDS Clinic Pharmacy DH Discharge Pharmacy Westwood Montbello Park Hill Lowry Other ________________</td></tr>
</table>

Clinic Portion:

(May be provided by Provider or other designated individual)

<table>
<tr><td colspan="6">New Request Renewal Request Urgent (Life Sustaining Only) **</td></tr>
<tr><td colspan="2">Attending Fellow Resident</td><td colspan="2">Pager:</td><td colspan="2">Clinic Name:</td></tr>
<tr><td colspan="3">Contact Person:</td><td colspan="2">Phone:</td><td>Fax:</td></tr>
<tr><td colspan="3">Completed By (if different):</td><td colspan="3">Email Address (if non-DH):</td></tr>
<tr><td colspan="6">PATIENT DIAGNOSIS:</td></tr>
<tr><td colspan="6">How long will pt be on this med?</td></tr>
<tr><td colspan="2">Will drug need to be titrated? Yes No</td><td colspan="4">If yes, what doses?</td></tr>
<tr><td colspan="6">Medical Rationale/ Necessity: May provide clinical documentation for medical necessity (ie encounters, lab, radiology, etc.).</td></tr>
<tr><td colspan="6">Is the patient currently receiving this drug? Yes No If yes, greater than 3 mo? Yes No</td></tr>
<tr><td colspan="6">Please list all other medications the patient has tried for this diagnosis and duration of use.</td></tr>
<tr><td colspan="6">Comments:</td></tr>
<tr><td colspan="6">For DHMP Medical Services Use Only</td></tr>
<tr><td colspan="2">Approved</td><td colspan="2">Denied</td><td colspan="2">Withdrawn (fax back to Pharmacy and Provider)</td></tr>
<tr><td colspan="6">Comments:

Signature:______________________________ Date:____________ _ Rx Begin Date:____________ End Date:_____________
Medical Director of Denver Health Medical Plan</td></tr>
</table>

For after-hours **urgent requests, please call the Caremark Help Desk @ 1-800-345-5413

Updated on 11/05/2009