# Drug Preauthorization Form

Please complete this form in its entirety. Incomplete forms may be returned to sender for additional information. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained from Avera Health Plans. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: ______________________________ Date of Birth: ______________

Member ID Number: ______________________________ Group Number: ______________

ICD code(s), please list all that apply: ______________________________

NPI number of administering facility: ______________________________

Requested start date of preauthorization: ______________________________

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**Please complete the following:**

| Drug Name | CPT/HCPCS Codes (if applicable) | Dose & Schedule |
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**Previous drugs tried, if applicable (doses & dates not needed):**

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**Please provide any supporting clinical literature if use is not considered standard of care (if applicable):** ______________

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**Determination of medical necessity requires the submission of documentation.**

- ☐ Clinical documentation is available in the Avera electronic medical record for review.
  Please list date(s) of pertinent records: ______________________________
- ☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Prescriber Name: ______________________ Today's Date: ______________________

Person completing the form: ______________________ Your Office/Facility Name: ______________________

Your Phone Number: ( _____ ) ______________________ Your Fax Number: ( _____ ) ______________________

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**Final determination will be faxed to the prescriber. Final determination will be mailed to the member.**

**IMPORTANT NOTICE*:*** This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim to Avera Health Plans. If you have questions about your benefits, please contact Avera Health Plans Customer Care team at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send secure email to Pharmacy@AveraHealthPlans.com.