ProCare Rx

Pneumovax® pneumococcal vaccine polyvalent

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Pneumovax®. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Will medication be administered at MD's office? YES NO
2. Is the patient younger than 2 years of age? YES NO
3. Is patient immunocompetent? (If NO, please continue on question #4) YES NO
4. Does patient meet any of the following criteria? (check all that apply)
   - ☐ Chronic cardiovascular disease
   - ☐ Chronic pulmonary disease
   - ☐ Diabetes mellitus
   - ☐ Alcoholism, chronic liver disease or cerebrospinal fluid leaks
   - ☐ Functional or anatomic asplenia (including sickle cell disease and splenectomy)
   - ☐ Alaskan native or American Indian
   - ☐ Age over 50 years
5. Does patient meet any of the following criteria? (check all that apply) YES NO
   - ☐ HIV Infection
   - ☐ Leukemia
   - ☐ Lymphoma
   - ☐ Hodgkin's disease
   - ☐ Multiple myeloma
   - ☐ Generalized malignancy
   - ☐ Chronic renal failure or nephritic syndrome
   - ☐ Receiving immunosuppressive chemotherapy (including corticosteroids)
   - ☐ Receive an organ or bone marrow transplant

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.procarerx.com. Medical Review Criteria are reviewed at least annually. Revised 09/2015