ProCare Rx

Tamiflu®

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

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Tamiflu®**. 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. Which is the requested medication being prescribed for? ☐ Treatment of Active Infection OR ☐ Prophylaxis
2. Was the onset of symptoms within the last 48 hours? YES NO
3. Was the patient immunized within the last 14 days? YES NO
4. Is the patient at high risk for developing influenza (as identified by CDC guidelines)? YES NO

   If YES, please specify risk factors: (check all that apply)

   - ☐ Age 65 or older
   - ☐ Nursing home/chronic care facility resident
   - ☐ Chronic heart, lung or kidney disease
   - ☐ Severe anemia
   - ☐ Other (please specify): _____
   - ☐ Diabetes
   - ☐ On immunosuppressive therapy
   - ☐ On long-term aspirin therapy
   - ☐ Asthma

5. Is the patient in close contact with an individual infected with influenza? YES NO

   If YES, what type of influenza does the contact have: _____

   Was the exposure within the last 48 hours? YES NO
6. Has there been an outbreak of influenza in the patient's community? YES NO

   If YES, what type of influenza is prevalent in the community? _____
7. If for Influenza Type A, does the patient have contraindication to amantadine or rimantadine therapy? YES NO

   If YES, please specify the nature of the contraindication: _____
8. What is the patient's current weight? _____

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.