



# Drug Preauthorization Form

Please complete this form in its entirety. 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: \_\_\_\_\_

If provider administered, where will the medication be given? \_\_\_\_\_

Requested start date of preauthorization: \_\_\_\_\_

**Please complete the following:**

Drug Name	CPT/HCPCS Codes (if applicable)	Dose & Schedule

**Previous drugs tried, if applicable (doses & dates not needed):**

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

**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: ( \_\_\_\_\_ ) \_\_\_\_\_

**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 DAKOTACARE. If you have questions about your benefits, please contact DAKOTACARE Service Center at 605-334-4000 or toll-free at 1-800-658-5508. 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 DAKOTACARE at **1-605-274-3279** or send a secure email to [Pharmacy@DAKOTACARE.com](mailto:Pharmacy@DAKOTACARE.com).