January 10, 2014

**IMPORTANT ANNOUNCEMENT**

Please read carefully and
keep this letter for your records

Beginning January 1, 2014, Alameda Alliance for Health (Alliance) contracted with a new Pharmacy Benefit Manager, PerformRx, to process pharmacy claims and prior authorizations. This announcement provides new prior authorization submission information.

## New Prior Authorization Phone and Fax Numbers Starting January 1, 2014

<table>
<tr><th>Program</th><th>New PerformRx Call Center</th><th>New Prior Authorization Fax</th></tr>
<tr><td>Alliance CompleteCare (HMO SNP)<br>(Medicare Part D Program)</td><td>1-855-251-0966<br>Hours: 24/7</td><td>Standard: 1-855-811-9327<br>Urgent: 1-855-851-4054</td></tr>
<tr><td>Medi-Cal</td><td rowspan="2">1-855-508-1713<br>Hours: 8:30-5:30 PST<br>Mon-Fri</td><td rowspan="2">Standard and Urgent:<br>1-855-811-9329</td></tr>
<tr><td>Alliance Group Care (IHSS)</td></tr>
</table>

## New Prior Authorization Forms

New Prior Authorization Forms are attached and located on our website in a convenient, fillable PDF format:

*www.alamedaalliance.org* ➔ *Providers* ➔ *Pharmacy and Drug Benefits* ➔

***2014 Medi-Cal/Group Care Prior Authorization Form*** *or*

***2014 Alliance CompleteCare Medicare Coverage Determination Request Form***

## New Online Prior Authorization Submission URLs

Submit a prior authorization request online through PerformRx's web submission form located in the Alliance Provider Portal:

*www.alamedaalliance.org* ➔ *Providers* ➔ *Log In* ➔ *New 2014 Prior Authorization Forms* ➔

*Select appropriate link for each line of business*

Not yet registered? Register under **Provider Log-In** to create your user account.

## New Phone and Fax Number for Diplomat Specialty Pharmacy

Specialty injectable medications will continue to be dispensed through Diplomat Pharmacy

Phone: **1-855-347-4783**, Fax: **1-855-399-3248**

**Need assistance?** Speak to an Alliance Provider Service Representative at (510) 747-4510.

# Alameda Alliance for Health
# Medication Request Form

**Attn: Prior Authorization Department**

**200 Stevens Drive**
**Philadelphia, PA 19113**
**Phone (Medi-Cal/Group Care): 1-855-508-1713**
**Phone (AllianceSELECT): 1-855-508-1717**
**Fax: 1-855-811-9329**

**Instructions:**

This form is to be used by participating providers to obtain coverage for a formulary drug with PA guideline, other restrictions, or a non-formulary drug for which there is no suitable alternative available. Please complete this form and fax it to **PerformRx** at 1-855-811-9329 or call with this information. If you have any questions regarding this process, please contact **PerformRx's** Provider Service Line at 1-855-508-1713 for Medi-Cal/Group Care and 1-855-508-1717 for AllianceSELECT.

☐ **Urgent Request** (Must be reserved for requests that, in the provider's best professional judgment, are potentially life threatening or pose a significant risk to the continuous care of the patient.)

| Patient Name | | |
|---|---|---|
| Patient DOB | Patient ID Number | |
| Prescriber Name | Specialty | |
| Prescriber Phone | Prescriber Fax | NPI# |
| Prescriber Address | | |
| Pharmacy Name | Pharmacy Phone | Pharmacy Fax |
| Medication Name and Strength Requested:<br><br>☐ Brand Medically Necessary request (Rationale required below) | | |
| Directions: | Quantity Requested: | |
| Anticipated Length of Therapy:<br><br>☐ _______Days ☐ 3 Months ☐ 6 Months ☐ 12 Months | | |
| Diagnosis: | | |
| | | |
| Preferred Medications tried/previous therapy, please include strength, frequency and duration: | | |
| | | |
| | | |
| Rationale and/or additional information, which may be relevant to the review of this prior authorization request: | | |
| | | |
| | | |
| | | |
| Prescriber Signature | Date | |

**Please Fax Completed Form to 1-855-811-9329**

ALAMEDA Alliance FOR HEALTH
Health care you can count on. Service you can trust.

PERFORMRx
Next Generation Pharmacy Benefits

200 Stevens Drive
Attention: Prior Authorization
Philadelphia, PA 19113
Phone: (855) 251-0966
Standard Fax: (855) 811-9327
Urgent Fax: (855) 851-4054

# Medicare Part D Coverage Determination Request Form

This form **cannot** be used to request:

- Medicare non-covered drugs, including fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

**Plan Name:**

| **Patient Information** | | | **Prescriber Information** | | |
|---|---|---|---|---|---|
| Patient Name: | | | Prescriber Name: | | |
| Member ID# | | | DEA# | | |
| Address: | | | Address: | | |
| City: | | State | City: | | State: |
| Home Phone: | | Zip: | Office Phone# | Office Fax: | Zip: |
| Sex (circle): M F | DOB: | | Contact Person: | | |

| **Diagnosis and Medical Information** | | | |
|---|---|---|---|
| Medication: | Strength and Route of Administration | | Frequency: |
| ☐ New Prescription OR Date Therapy Initiated**:** | Expected Length of Therapy: | | Qty: |
| Height/Weight: | Drug Allergies: | Diagnosis: | |
| **Prescriber's Signature:** | | | Date: |

**Rationale for Exception Request or Prior Authorization**
**FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure)
- **Specify below**: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
- **Specify below**: Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage
- **Specify below**: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

Request for formulary tier exception
- **Specify below**: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other:______________________________________________ Explain below

**REQUIRED EXPLANATION:** ______________________________________________

______________________________________________

______________________________________________

**Request for Expedited Review**

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
- BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

**Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA**