SmartHealth®

**SmartHealth precertification/**
**PA fax:** 512-831-5499

## Medical specialty precertification/prior authorization request

Please submit all inquiries for prior authorization requests via the Online Provider Portal at https://bit.ly/AscensionProviderPortal. The Online Provider Portal is an all access entry into your authorization requests and determinations. For questions about a medical specialty drug prior authorization, please contact the team at 833-980-2352.

Smarthealth member ID: _____

Please indicate: ☐ Start of treatment - Start date: _____/_____/_____
☐ Continuation of treatment - Date of last treatment: _____/_____/_____

Priority:
☐Urgent
☐Routine

Precertification requested by: _____ Phone: _____ Fax: _____

| A. PATIENT INFORMATION | | | |
|---|---|---|---|
| First Name: | Last Name: | DOB: | |
| Address: | City: | State: | ZIP: |
| SmartHealth ID: | Phone: | Email: | |
| Patient Current Weight: lbs or kgs | Patient Height: inches or cms | Allergies: | |

| B. PRESCRIBER INFORMATION | | | |
|---|---|---|---|
| First Name: | Last Name: *(Check One):* M.D. D.O. N.P. P.A. | | |
| Address: | City: | State: | ZIP: |
| Phone: | Fax: | | |
| NPI #: (REQUIRED) | Tax ID: (REQUIRED) | | |
| Contact Name: | Contact Email: | Contact Phone: | |

**C. DISPENSING PROVIDER/ADMINISTRATION INFORMATION**

Place of Administration:
☐ Self-Administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Administration Code(s) (CPT): _____
Address: _____
NPI (REQUIRED): _____
Tax ID (REQUIRED): _____

Place of Dispensing (Provider/Pharmacy):
☐ Physician's Office ☐ Retail Pharmacy
☐ Hospital Based Medication ☐ Clinic Medication
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____
Fax: _____
NPI: _____

| DIAGNOSIS INFORMATION | | |
|---|---|---|
| Diagnosis: | Staging: | ICD-10: |

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## E. CLINICAL INFORMATION – Provide medical necessity documentation for the requested medication including other medications tried (attach supporting documentation).

*Clinical documentation to support medical necessity should be faxed back along with the completed form.*

## F ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*:__Date:___/_____/_____

## G. MEDICATION(S)/ONCOLOGY OR COMPLEX REGIMEN

| | | | |
|---|---|---|---|
| **1** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **2** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **3** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **4** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **5** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **6** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |
| HCPCs Code: | | National Drug Code (NDC): *(if available)* | |
| **7** Medication Name/Strength: | | Dosing per Administration: | |
| Route of Administration: | Quantity: | Day Supply: | Expected Duration of Therapy: |