Pharmacy Transition of Care Report

"CONFIDENTIAL INFORMATION"

If you're taking any of the medications listed below in **STEP 2**, WHP requires this form to be completed by your prescribing physician in order to approve your current RX up to a 90-day supply. If your medication appears on our current SPL as requiring Prior Authorization/Step-Edit, you need to **fill out STEP 1** and **have your physician complete STEP 2** in order to be considered for coverage. Visit www.welbornhealthplans.com for a current and complete SPL listing.

STEP 1:

Employee's Name: ____________________

Subscriber's Social Security #: ____________________

Address: ____________________

Telephone #: Home: ____________________ Work: ____________________

Patient's Name: ____________________

Physician's Name: ____________________ Contact #: ____________________

Drug & dosage requesting: ____________________

Medical Diagnosis: ____________________

I authorize Welborn Health Plans to have access to all medical, hospital, or other institutional or agency records regarding the diagnosis, treatment, or services provided to me and/or my covered dependents to such extent as may be lawful.

Employee Signature	**Date**	**Patient Signature**	**Date**

As a new member, you are approved for up to a ***90-day supply*** *while your paperwork is being processed – call Member Services at (812) 426-6600, Monday through Friday, 8am to 5pm (CST) with any questions.*

STEP 2:

This portion is for the *prescribing physician* to complete (only the applicable section).

How long is has the Member been receiving the drug? ____________________

Is it effective for the condition being treated? ____________________

Was the Member intolerant to alternative drugs or were they ineffective? ☐ Yes ☐ No

☐ **PPI (Aciphex, Nexium, Prevacid, Prilosec 40 mg, Protonix, other ___________)**

1) Does patient have alarm symptoms such as (dysphagia, odynophagia, weight loss, GI bleeding, hoarseness, or pulmonary symptoms)? ☐ Yes ☐ No
2) Previous therapies tried for condition (i.e. H_2 antagonist, OTC Prilosec): ____________________
3) Has Member had an upper endoscopy to evaluate disease? ☐ Yes ☐ No

☐ **Cox II (Celebrex, other ___________)**

1) Previous therapies tried for condition (i.e. other NSAIDS): ____________________
2) List any risk factors for GI adverse events (i.e. hx peptic ulcer disease, age >60, other concomitant use of anticoagulants): ____________________

☐ **Step-Edit Program Drugs (Actos, Avandia, Avandament, Gabitril, Oxycontin, Topomax, Zetia, other)**

1) Previous therapies tried for condition: ____________________

☐ **Allergy (Allegra, Allegra-D, Clarinex, Zyrtec, Zyrtec-D, other ___________)**

1) Has Member tried and failed OTC loratidine? ☐ Yes ☐ No
2) Has Member tried and failed a Nasal Steroid? ☐ Yes ☐ No

☐ **Biotech (Growth Hormone, Avonex, Betaseron, Copaxone, Pegasys, Enbrel, other ___________)**

1) *Fax any pertinent lab data, treatment plan, and follow-up histories related to this treatment.*

Physician Signature	**Date**	**Contact Number**

STEP 3:

Fax completed form to: Welborn Health Plans, Pre-Certification Department: (812) 773-0544 (Fax)

Call (812) 426-6600 (Option 3) with questions. Or mail to: Welborn Health Plans, ATTN: Health Services, 101 S.E. Third Street, Evansville, IN 47708.