ProCare Rx

Step Therapy Medication Medical Necessity Form

A. Member Information			
Patient Name:			
Cardholder ID #:	Patient Date of Birth:	Patient Contact Phone #:	
Address:	City:	State:	Zip:

B. Physician Information			
Physician Name:	Specialty:		
Physician Phone #:	Physician Fax #:		
Address:	City:	State:	Zip:

D. Clinical Information *(Please provide all requested information. Incomplete forms will be returned for additional information.)*	
Medication Required:	
Previous treatment options that were utilized:	
Please explain the therapy failure (adverse effects) that was experienced during the course of treatment:	
Please explain the rationale for prescribing the requested medication over the formulary option that is available. *(Please do not answer "Drug of Choice"):*	
Medical history that is relevant to this diagnosis:	
Authorized Medical Signature:	**Date:**

For EHIM Use Only		
Date and Time Received:	Prior Authorization Reference #:	
Pharmacy Name:	Pharmacy Phone:	
Approved ☐ Denied ☐ by:		Approval Expiration Date:
Date/time returned to provider:		
Comments:		

Please fax completed form to (248) 948-9904, ATTN: EHIM, Powered by ProCare Rx, Clinical Management

EHIM, Powered by ProCare Rx
26711 Northwestern Highway, Suite 500
Southfield, MI 48033

Fax: (248) 948-9904 | Website: www.ehimrx.com