MEDICAL MUTUAL®

Prior Approval Form

Please print with black ink or fill in using Acrobat® Reader®. An electronic version of this Prior Approval Form is available in the *Tools & Resources, Forms* section of Provider.MedMutual.com. For a list of medications and services requiring prior approval or considered investigational, visit the Prior Approval and Investigational Services list located in *Tools & Resources, Care Management* section of our Provider website.

Date:_____

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State & Zip)	
Identification No.	Group No.

PROVIDER INFORMATION

Provider Name (Last, First)	NPI No.
Mailing Address (Street, City, State & Zip)	Phone Number
Requester/Title (if different than prescriber)	Phone Number
Provider Signature	Date

REASON FOR PRIOR APPROVAL

❑ Procedure ❑ Durable Medical Equipment (DME) ❑ Device ❑ Medication—Injectable and Infusion (Complete Medication Prior Approval section **only**) ❑ Other—Describe

Description of Service (Please specify exact services being requested.)

Diagnosis

ICD-9-CM Diagnosis Code(s)

Is this an established diagnosis for the patient? ❑ Yes ❑ No

CPT/HCPCS Code(s)

Place of Service ❑ Office ❑ In/Outpatient Facility ❑ Home ❑ SNF ❑ Other—Describe

Is there previous history of services relating to this prior approval? ❑ Yes ❑ No If yes, please describe.

MEDICAL NECESSITY STATEMENT AND DOCUMENTATION

The following documentation is enclosed for review of this prior approval request...

❑ Office Notes ❑ Medical Records ❑ X-rays ❑ Photos ❑ Other—Describe

MEDICATION PRIOR APPROVAL* (Please complete one form per medication being requested)

❑ New Request (Proceed to Diagnosis) ❑ Renewal of previous approval

Has the requested medication been effective? ❑ Yes ❑ No ❑ Not applicable

If no or not applicable, please explain.

*Complete this form for an injectable or infusion being requested under the member's **medical benefit**. When these medications are provided under a member's prescription drug benefit, please contact the pharmacy benefit manager at the number on the member's identification card for prior approval requirements.

Diagnosis

ICD-9-CM Diagnosis Code(s)

Weight (lbs.)

Requested Medication

Dose	Frequency	Route
CPT/HCPCS Code		NDC

Requested length of treatment

Place of Service ❑ Office ❑ Outpatient Facility ❑ Infusion Center ❑ Pharmacy ❑ Other—Describe

Medical Necessity (clinical and treatment history). Include medications adverse effects and conditions.

The following documentation is enclosed for review of the prior approval request...

❑ Office Notes ❑ Medical Records ❑ Other—Describe

For Procedures, Durable Medical Equipment, Devices and Other Services, fax this form with the medical necessity documentation to 877.321.6664 or mail to:

Medical Mutual of Ohio
Medical Review Department (MZ: 01-6A-3982)
2060 East Ninth Street
Cleveland, Ohio 44115-1355

Fax Medication prior approval requests to Medical Drug Management at 888.820.4028.