



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

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

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:		
<input type="checkbox"/> Brand Medically Necessary request (Rationale required below)		
Directions:		Quantity Requested:
Anticipated Length of Therapy:		
<input type="checkbox"/> _____ Days <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 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

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:
Sex (circle): M F		DOB:	Contact Person:		
Diagnosis and Medical Information					
Medication:		Strength and Route of Administration		Frequency:	
<input type="checkbox"/> 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					
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure) <ul style="list-style-type: none"> ➤ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); 					
<input type="checkbox"/> 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 <ul style="list-style-type: none"> ➤ Specify below: Anticipated significant adverse clinical outcome 					
<input type="checkbox"/> Medical need for different dosage form and/or higher dosage <ul style="list-style-type: none"> ➤ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason 					
<input type="checkbox"/> Request for formulary tier exception <ul style="list-style-type: none"> ➤ 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: _____ <input type="checkbox"/> Explain below					
REQUIRED EXPLANATION: _____					

Request for Expedited Review					
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] <ul style="list-style-type: none"> ➤ 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					