



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 evaluate coverage of these items. 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

STEP 2:

This portion is for the <i>prescribing physician</i> to complete (only the applicable section).	
How long 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2) Previous therapies tried for condition (i.e. H ₂ antagonist, OTC Prilosec): _____	
3) Has Member had an upper endoscopy to evaluate disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> 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): _____	
<input type="checkbox"/> Step-Edit Program Drugs (Actos, Avandia, Avandament, Gabitril, Oxycontin, Topomax, Zetia, other)	
1) Previous therapies tried for condition: _____	
<input type="checkbox"/> Allergy (Allegra, Allegra-D, Clarinex, Zyrtec, Zyrtec-D, other _____)	
1) Has Member tried and failed OTC loratidine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2) Has Member tried and failed a Nasal Steroid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Biotech (Growth Hormone, Avonex, Betaseron, Copaxone, Pegasys, Enbrel, other _____)	
1) <i>Fax any pertinent lab data, treatment plan, and follow-up histories related to this treatment.</i>	

Physician Signature

Date

Contact Number

STEP 3:

Fax completed form to: Welborn Health Plans, Pre-Certification Department: (716) 541-6344 (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.