



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, 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. H₂ 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, 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: (716) 541-6344 (Fax)
Call (812) 426-6600 with questions. Or mail to: Welborn Health Plans, ATTN: Health Services, 101 S.E. Third Street, Evansville, IN 47708.