SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Unclassified Medical Benefit Drug

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory surgery center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Infusion center ☐ Long term care center ☐ Member's home ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year) / Requested service/procedure		Procedure code(s)
Diagnosis	Diagnosis code(s)	
NDC code(s)	Dose/strength	
Frequency	Desired length of therapy	
Route: ☐ IV ☐ SQ ☐ Other _____		

Answer all of the following questions.

What medication(s) will the member be receiving:

- – Aimovig (erenumab-aooe) ..... ☐ Yes ☐ No
- – Akynzeo (fosnetupitant/palonosetron) ..... ☐ Yes ☐ No
- – Cysvita (burosumab-twza) ..... ☐ Yes ☐ No
- – Dupixent (dupilumab) ..... ☐ Yes ☐ No
- – Haegarda (C1 esterase inhibitor) ..... ☐ Yes ☐ No
- – Imfinzi (durvalumab) ..... ☐ Yes ☐ No
- – Libtayo (cemiplimab-rwlc) ..... ☐ Yes ☐ No
- – Lumoxiti (moxetumomab pasudotox-tdfk) ..... ☐ Yes ☐ No
- – Takhzyro(lanadelumab-flyo) ..... ☐ Yes ☐ No

If not on the list, what medication _____

Previous therapies tried ..... ☐ Yes ☐ No

If yes, please list _____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224

