GlobalHealth Transition of Care Request Form - Prescriptions
Please complete and fax back to 405-280-5613
or mail to **GlobalHealth Pharmacy Dept. | 6120 S. Yale Ave. Ste. 925 | Tulsa OK 74136**

Please complete this form if you are taking prescription medications that are currently covered by another insurance company. This is necessary, even if your current doctor and pharmacy are in GlobalHealth's network. Please complete a separate form for each patient. Photocopies of this form are acceptable. **THIS FORM IS NOT INTENDED FOR USE BY GENERATIONS MEMBERS.**

Employer	Cardholder ID # (if available)	Date of Enrollment in GlobalHealth Benefit Plan (mm/dd/yyyy)

Employee Name	Employee SSN	Work Phone
		( )_____-_____

Home Address (Street, City, State, Zip)	Home Phone
	( )_____-_____

Patient's Name	Patient's SSN	Patient's DOB (mm/dd/yyyy)	Relationship to Employee
			☐Self ☐Spouse ☐Child

Which of the following BRAND-NAME prescriptions does this patient take? Check all that apply.
(Most generic medications do not require prior authorization.)

☐Abilify	☐Benlysta	☐Claravis	☐Focalin	☐Linzess	☐Nuvigil	☐Trulicity
☐Advair	☐Botox	☐Combivent	☐Gilenya	☐Lupron	☐Otezla	☐Viekira
☐Amitiza	☐Breo Ellipta	☐Contrave	☐Glyxambi	☐Lyrica	☐Restasis	☐Vyvanse
☐Apriso	☐Brilinta	☐Copaxone	☐Harvoni	☐Makena	☐Sovaldi	☐Xarelto
☐Asacol HD	☐budesonide	☐Dymista	☐Humira	☐modafinil	☐Strattera	☐Xifaxan
☐Asmanex	☐Butrans	☐Effient	☐Invokana	☐Myrbetriq	☐Suboxone	☐Xiidra
☐Avonex	☐Byetta	☐Eliquis	☐Januvia	☐Nasonex	☐Symbicort	☐Xolair
☐Belsomra	☐Bystolic	☐Enbrel	☐Jardiance	☐Nexium	☐Tecfidera	
☐Belviq	☐Cimzia	☐Euflexxa	☐Latuda	☐Novolog	☐Tradjenta	

This is intended to be a representative list and should not be considered an exhaustive or conclusive list of medications that are subject to prior authorization, step therapy, or other utilization management reviews. If you are taking one or more BRAND-NAME medications similar to one of those named above, please list them below. Feel free to attach a medication history from your pharmacy.

_____

_____

Please provide as much information as possible about the physician(s) who prescribe these medications for you. Attach additional pages if necessary.

Physician Name	Physician's Phone #	Physician's Fax #
	( )_____-_____	( )_____-_____

Physician's Practice Address (Street, City, State, Zip)	Type of prescriber
	☐MD ☐Nurse Practitioner ☐DO ☐Physician's Asst.

Medication(s) prescribed by this physician:	If NP or PA, who is the collaborating dr?

I hereby authorize the above physician(s) to provide GlobalHealth or any affiliated GlobalHealth company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. This authorization will expire 24 months from the date signed. I understand I may revoke this authorization at any time by writing to the address listed at the top of this form. I understand that I cannot restrict information that may have already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.

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Signature of patient, parent, or guardian Date