



UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:

Plan/medical group phone number: 1-866-461-7272

Plan/medical group fax number: 1-888-447-3430

<input type="checkbox"/> Urgent ¹	<input type="checkbox"/> Non-Urgent
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Requested Drug Name:		
Is this drug intended to treat opioid dependence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes , is this a first request for prior authorization for this drug? * If Yes, prior authorization is not required. No need to complete this form.	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
If No , what was the date of the first request? Date: * If greater than twelve (12) months since the first request, prior authorization request form is not required.		

Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	New Request	Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):		
Drug(s) Requested (with J-Code, if applicable):		
Strength/Route/Frequency:		

Unit/Volume of Named Drug(s):		
Start Date and Length of Therapy:		
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:		
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response:		
For use in clinical trial? (If yes, provide trial name and registration number):		
Drug Name (Brand Name and Scientific Name)/Strength:		
Dose:	Route:	Frequency:
Quantity:	Number of Refills:	
Product will be delivered to:	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Physician Office
		<input type="checkbox"/> Other:
Prescriber or Authorized Signature:		Date:
Dispensing Pharmacy Name and Phone Number:		
Approved	Denied	
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:		

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request; or is a prior authorization request for medication-assisted treatment for substance abuse disorders.