UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

☐ **Urgent** [1]	☐ **Non-Urgent**		
Requested Drug Name:			
Is this drug intended to treat opioid dependence?		☐ **Yes**	☐ **No**
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***	☐ **No**
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 Information:	**Prescribing Provider Information:**
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:

Internal Information

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: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]			
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:	☐ Patient's Home	☐ Physician Office	☐ 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.

Internal Information