

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ Provider ID Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information

Medication: _____ Quantity: _____ ICD-10 Code: _____

Directions: _____ Diagnosis: _____ Refills: _____

Physician Signature**: _____ DAW (Initial here): _____

Physician Signature:** By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? Yes No

Is this medication a **New Start**? Yes No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

Delivery Instructions

Note: Delivery coordination requires a **"Physician Signature"** above and complete **"Provider Information"** and **"Patient Information"**

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office Patient's Address Date medication is needed: / /

Medication Administered: Home Health Self Administered LTC Physician's Office



**Medical Exception Worksheet/Prescription Order Form
Specialty Pharmacy (ORAL / INJECTABLE) Medication**
Please complete and return fax to 866-940-7328

PATIENT DEMOGRAPHICS / INSURANCE INFORMATION

Patient Name: _____ Unison ID #: _____
 Insured's Name: _____ Insured's SSN/Group #: _____
 Primary Insurance Information: ID #: _____ Group #: _____
 Secondary Insurance Information: ID#: _____ Group #: _____
 Patient Mailing Address: _____ DOB: _____
 Patient Phone day: (_____) _____ Evening: (_____) _____
 Best time to Contact: _____ Sex: M F Primary language: _____

PRESCRIPTION (Required)

Drug/Strength/Dose: _____ Coordinating administration supplies Sig: _____
(As required by PA law, generics will be dispensed if available)
 MD Name: _____ MD Signature (required): _____
 DEA #: _____ MD License #: _____ NPI # (Required): _____
 Physician Address: _____ City, State Zip: _____
 Physician Phone #: (_____) _____ Physician Fax #: (_____) _____

For injectable medications only:
 Medication to be Administered: Physician's Office (**In Office / Outpt Facility**) Patient's Home (**Administered**)
 Deliver Rx to: Physician's Office Patient's Home Other Address: _____
 Contact Person/Ext.: _____ Date Needed: _____ QTY: _____ Duration: _____

CLINICAL INFORMATION

Clinical Diagnosis: _____ ICD-10 Code: _____
Pregnancy Status: YES NO If yes, Expected Due Date: _____
 Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives:
 (i.e. past prescription treatment failures, documented side effects, lab values, etc.)

Formulary Medication Attempted	Dose	Dates of Therapy	Reason for Discontinuing Therapy

Height: _____ Weight: _____ Allergies (including food): _____
 Current Patient Medication Profile including OTCs & herbals: (drug / dose / directions)

 Additional Information: _____

Physician Signature:** By signing above the physician is providing Prescription Solutions with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication. The Physician Signature** above is not required if the physician will supply the medication directly to the patient, if the patient has already been provided with a written prescription or if the physician will provide the prescription to a pharmacy via phone or fax.

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