

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____
 Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:	Last Name: _____ M.D./D.O.		
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

Is this member pregnant? Yes No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Clinical and Drug Specific Information

- Does the patient have a diagnosis of Duchene muscular dystrophy? Yes No

Section F – Additional information and Explanation of why preferred medications would not meet the patient's needs
 Please refer to www.uhccommunityplan.com for a list of preferred alternatives

Physician Signature: _____ **Date:** _____

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