UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
Phone: (800) 882-4462 Fax: (855) 840-1678

As of January 1, 2020, no prior authorization requirements may be imposed by a carrier for any FDA-approved prescription medications on its formulary which is approved to treat substance use disorders.

☐ **Urgent** [1]	☐ **Non-Urgent**	
Requested Drug Name:		
Is this drug intended to treat opioid dependence?	**Yes** ☐	**No** ☐
If **Yes,** is this a first request within a 12 month period for prior authorization for this drug? *** If Yes, prior authorization is not required for a 5-day supply of any FDA-approved drug for the treatment of opioid dependence and there is no need to complete this form.** ***If No, as of January 1, 2020, a prior authorization is not required for prescription medications on the carrier's formulary and there is no need to complete this form.**	**Yes*** ☐	**No*** ☐

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:

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.