

Plan name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]  
Email: \_\_\_\_\_

**Is this request urgent?** Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. –Or– In the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is urgent and meets the definition as indicated above, please check this box.

**Urgent request**

**Uniform Prior Authorization  
Prescription Request Form**

Date: [ ] / [ ] / [ ]

Verify with the preauthorization list on the **“One Health Port” hyperlink**, according to the company's procedure, or call the number on the back of the member's card.

Is this request:  New  Authorization extension  Providing additional information

If you already have an authorization number, list it here: \_\_\_\_\_

**1. Patient information**

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Member ID #: \_\_\_\_\_ and Group number: \_\_\_\_\_

Secondary insurer member ID #: \_\_\_\_\_ and Group number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Male  Female DOB: [ ] / [ ] / [ ]

Allergies: \_\_\_\_\_

**2. Prescriber / Provider information**

Check one: You are the  Requesting provider  Servicing provider  Specialty: \_\_\_\_\_

Provider name: \_\_\_\_\_ Tax ID number: \_\_\_\_\_

Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]

NPI: \_\_\_\_\_ DEA number (if required): \_\_\_\_\_

Provider address: \_\_\_\_\_

Who should we contact if we require more information? Name: \_\_\_\_\_

Phone: [ ] - [ ] - [ ] Fax: [ ] - [ ] - [ ]

**3. Patient's PCP information (if applicable)**

Name: \_\_\_\_\_  
Phone: [ ] - [ ] - [ ] ext. [ ] Fax: [ ] - [ ] - [ ]

**4. Medication / Medical and Dispensing Information**

Medication name: \_\_\_\_\_

Dose/strength: \_\_\_\_\_ Frequency: \_\_\_\_\_ Length of therapy/#refills: \_\_\_\_\_ / \_\_\_\_\_ Quantity: \_\_\_\_\_

New therapy     Renewal    If Renewal: date therapy initiated [ ] / [ ] / [ ]

Route of administration:  Oral/SL     Topical     Injection     IV     Other: \_\_\_\_\_

Administered:  Doctor's office     Dialysis center     Home health     By patient     Other: \_\_\_\_\_

**List of previous drugs tried**

Drug name:	Dosage:
_____	_____
_____	_____
_____	_____

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provide all ICD-9 or ICD-10 codes and their descriptions, if available; this will help us process your request.

Diagnosis: \_\_\_\_\_

Codes and descriptions are:     ICD-9     ICD-10

Primary: \_\_\_\_\_

Second: \_\_\_\_\_

Third: \_\_\_\_\_

**Submit the following clinical information with this form as appropriate for this request:** History & Physical • Lab/radiology/testing results • Current symptoms and functional impairments • Treatment history • *Any other information such as chart notes that support medical necessity for the request.* [\[Hyperlink to Plan's Pharmacy Policy\]](#)