

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____ Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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				
- What is the patient's diagnosis? <input type="checkbox"/> Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I) <input type="checkbox"/> Scheie form of Mucopolysaccharidosis I (MPS I) with Moderate to Severe Symptoms <input type="checkbox"/> Other, please list: _____				
Section F – Additional information and Explanation of why preferred medications would not meet the patient's needs				
<i>Please refer to www.uhccommunityplan.com for a list of preferred alternatives</i>				

Physician Signature: _____ **Date:** _____

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