

## Biltricide - Washington

**Prior Authorization Request Form** 

Please complete this <u>entire</u> 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.

Address:  City:   State:   ZIP Code:   Primary Insurance Information (if any):  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:   Is this patient currently hospitalized?   Yes   No   If recently discharged, list discharge date:   Is this patient currently hospitalized?   Yes   No   If recently discharged, list discharge date:   Is this patient currently hospitalized?   Yes   No   If recently discharged, list discharge date:   Is this patient currently hospitalized?   Yes   No   If recently discharged, list discharge date:   Is this member   Fax:   MD/D.O.   Address:   Is this member   Fax:   Is the primary   Is precious   Information   Is trength:   Is this member   Fax attention to:   Is this member   Fax attention to:   Is this member   Is this	Section A – Member Info	ormation					
State   DOB:   Altergies:	First Name:		Last Name:		Member ID:		
Primary Insurance Information (if any):  Is the requested medication:   Is this patient currently hospitalized?   Yes No If recently discharged, list discharge date:  Section B - Provider Information  First Name:  Last Name:  Address:  City:  Specialty:  Office Contact Name / Fax:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?   Yes No  If yes, what is this member's due date?  Clinical and Drug Specific Information  ALL REQUESTS  Is praziquantel being prescribed for one of the following? (If yes, check which applies)  Infections due to schistosoma  Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis vivemini (i.e., clonorchiasis)  Section E - Additional information and Explanation of why preferred medications would not meet the patient's needs:  Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives	Address:						
Primary Insurance Information (if any):	City:		State:		ZIP Code:		
Is the requested medication:   New or   Continuation of Therapy? If continuation, list start date:	Phone:		DOB:		Allergies:		
Is this patient currently hospitalized?	Primary Insurance Informatio	n (if any):					
Last Name:   Last Name:   MD/D.O.	Is the requested medica	ation: □ New or □	Continuation of Thera	apy? If continuation, li	st start date: _		
First Name:    Last Name:   MD/D.O.	Is this patient currently	hospitalized?	Yes □ No If recently	discharged, list discha	arge date:		
First Name:    Last Name:   MD/D.O.	Section B - Provider Info	ormation					
Phone:	First Name:		Last Name:		M.D./D.O.		
Office Contact Name / Fax attention to:  Section C - Medical Information  Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?	Address:		City:		State:	ZIP code:	
Section C - Medical Information  Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  ICD-10 CODE:  Is this member pregnant?	Phone:	Fax:	NPI #:		Specialty:		
Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?   Yes   No	Office Contact Name / Fax a	ttention to:	<u> </u>	•			
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Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?	Medication:				Strength:		
Is this member pregnant?   Yes   No	Directions for use:				Quantity:		
Is this member pregnant?   Yes   No							
Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation  Clinical and Drug Specific Information  ALL REQUESTS  Is praziquantel being prescribed for one of the following? (If yes, check which applies)  Infections due to schistosoma Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)  Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives	Diagnosis (Please be specific & provide as much information as possible):				ICD-10 C	ICD-10 CODE:	
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Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives		,					
Provider Signature: Data:	Please refer t	o the patient SP	DL at www.uncprovi	der.com for a list of	preferred alte	ernatives	
Provider Signature: Data:							
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