

## Exception to Rule (ETR) Request - Washington 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 is for Washington ETR requests only, not an appeal request or initial requests)**  
**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 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: \_\_\_\_\_

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

**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**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**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](http://www.uhcprovider.com) for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

- **Is this an Exception to Rule (ETR) request?**  Yes  No (If yes, Medical records must be submitted supporting this request)
  
- **Is the requested medication being used for an indication supported by information from the compendia of current literature?**  Yes  No  
 If yes, list supporting literature: \_\_\_\_\_
  
- **Is the requested medication being used for a condition supported by clinical literature from the physician?**  Yes  No (If yes, must attach clinical literature)
  
- **Does the prescriber attest that this treatment represents cost-effective use of public funds?**  
 Yes  No
  
- **Is the patient's clinical condition so different from the majority that there is no equally effective, less costly covered service or equipment that meets the patient's needs?**  Yes  No (If yes, must attach documentation)
  
- **Does the prescriber attest that medical treatment or items of service which are covered under the client's Washington apple health program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be one of the following?**  Yes  No  
 (check which applies)  
 Medically ineffective in the treatment of the client's condition  
 Inappropriate for that specific client

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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