

Nityr - 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 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 Info	ormation					
First Name:	: Last				Member ID:	
Address:						
City:	State:	State:			ZIP Code:	
Phone:	DOB:			Allergies:		
Primary Insurance Information	n (if any):	•				
Is the requested medica	ation: □ New or □	Continuat	ion of Ther	apy? If continuation,	list start date: _	_
Is this patient currently	hospitalized?	Yes □ No	If recently	discharged, list disc	harge date:	
Section B - Provider Info	ormation					
First Name:			Last Name:		M.D./D.O.	
Address:			City:		State:	ZIP code:
Phone:	Fax:		NPI #:		Specialty:	
Office Contact Name / Fax a						
Section C - Medical Information						
Medication: Strength:						
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?						
Section D – Previous Me	edication Trials					
Medication Name Stren		Dire	ctions	Dates of Therap		n for failure / ontinuation
	CI	inical and	d Drug Sp	ecific Information		
□ Yes □ No Doesthe	patient have a di	agnosis of	hereditary	tyrosinemia type 1?		
Section E – Additional in	nformation and Ex	planation	of why pref	erred medications wo	ould not meet th	e patient's needs:
Please rer	er to the patient's	PDL at ww	/w.uncprov	der.com for a list of p	preferred alterna	atives
Provider Signature: Date:						

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