



Universal Health Care, Inc. Pharmacy Department

Medicaid Prescription Authorization Request for Mental and Behavioral Health Drugs

Incomplete or illegible sections will result in processing delays. Requests are processed within 24-72 business hours.

MEMBER INFORMATION:

Member Name:	UHC ID:	Date Of Birth:
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PRIOR AUTHORIZATION REQUEST:

Drug Name:	Drug Strength:	Directions / Dose:
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Reason For Request: (Please attach medical documentation to support your request)

- Coverage for a Formulary Drug that requires Prior Authorization
- Override the Quantity Limitation: Quantity _____ Days _____
- Other (please specify) _____

Please answer each of the following questions. (Any omission will disqualify the Prior Authorization request):

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| 1. Is the prescriber qualified to manage the medication? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Is the medication FDA approved for use (e.g. age specifics, diagnosis) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Has the patient had a psychiatric evaluation in the past year? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Is the member currently engaged in behavioral health services? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Has the member tried and failed covered alternatives? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If yes for #5, please list;

Trial 1: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___

Trial 2: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___

Trial 3: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___

Diagnosis:

Significant Lab Values:

Medical Necessity Reason or Off-Label Use Documentation:

PRESCRIBER INFORMATION:

Prescriber's Full Name:	Prescriber Signature:
DEA/License Number:	Tax ID Number:

Universal Health Care Network Provider: YES NO

Fax: ()	Phone: ()	Contact Person:
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PLEASE SUBMIT YOUR REQUEST TO:

FAX: 727-329-3308 OR EMAIL: PHARMACY@UNIVHC.COM

For Member Services, please call: Phone: 1-866-690-4842 TTY: 1-800-617-0177