



Pharmacy Department

Prior Authorization Request Form

Please complete form. Incomplete or ineligible sections will result in processing delays. Requests are normally processed within 24-72 hours. Priority requests may be processed on day of receipt. All requests are effective from the date of approval.

Member Information:

Member Name:	UHC ID:	Date Of Birth:
--------------	---------	----------------

Prior Authorization Request:

Drug Name:	Drug Strength:	Directions / Dose:
------------	----------------	--------------------

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 _____
- Coverage for a Non-Formulary Drug
- Remove Coverage of a Drug due to: _____
- Brand Limit Override

Fill below portion for Formulary Drug that requires Step Therapy Trials:

Drug Name:	Drug Strength:	Directions / Dose:
------------	----------------	--------------------

Past Failures and Documentation of Reason for Past Failures:

Trial 1: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___
 Trial 2: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___
 Trial 3: _____ Dates of Therapy: Start ___/___/___ Discontinued ___/___/___

Diagnosis or Concurrent Disease Status:

Significant Lab Values:

Medical Necessity Reason or Off-Label Use Documentation:

Prescriber Information:

Prescriber Name:	Prescriber Signature:		
DEA/License Number:	TAX ID Number:		
Address:			
City	State:	Zip:	Phone: () -
Fax: () -	Contact Person:		

PLEASE FAX THIS REQUEST FORM TO UNIVERSAL HEALTH CARE AT: 727-329-3308