



**UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM
CONTAINS CONFIDENTIAL PATIENT INFORMATION**

Complete this form in its entirety and submit your request online and attach this form using our Prior Authorization and Notification Tool at www.UHCprovider.com/paan. You may also initiate your request by phone by calling the number on the back of the member's health plan ID card.

No carrier shall impose any prior authorization requirements for any FDA-approved Medication-Assisted Treatment used in the treatment of a substance use disorder

<input type="checkbox"/> Urgent ¹		<input type="checkbox"/> Non-Urgent	
Requested Drug Name:			
Is this drug being prescribed to treat substance use disorder?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Patient Information:		Prescribing Provider Information:	
Patient Name:		Prescriber Name:	
Member/Subscriber Number:		Prescriber Fax:	
Policy/Group Number:		Prescriber Phone:	
Patient Date of Birth (MM/DD/YYYY):		Prescriber Pager:	
Patient Address:		Prescriber Address:	
Patient Phone:		Prescriber Office Contact:	
Patient Email Address:		Prescriber NPI:	
		Prescriber DEA:	
Prescription Date:		Prescriber Tax ID:	
		Specialty/Facility Name (If applicable):	
		Prescriber Email Address:	
Prior Authorization Request for Drug Benefit:		<input type="checkbox"/> New Request <input type="checkbox"/> Reauthorization	
Patient Diagnosis and ICD Diagnostic Code(s):			
Drug(s) Requested (with J-Code, if applicable):			
Strength/Route/Frequency:			
Unit/Volume of Named Drug(s):			
Start Date and Length of Therapy:			
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:			
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]			
For use in clinical trial? (If yes, provide trial name and registration number):			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:		Route:	Frequency:
Quantity:		Number of Refills:	
Product will be delivered to:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician Office	<input type="checkbox"/> Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			
<input type="checkbox"/> Approved		<input type="checkbox"/> Denied	
If denied, provide reason for denial, and specify which drugs and dosages in the same class as the drug for which the prior authorization request was denied are covered under the covered persons plan			

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.