

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to <u>www.uhccommunityplan.com</u> for medication fax request forms.)

Detient Information			
Patient Information			
Patient's Name:			
Insurance ID:	Date of Birth:	Height: Weigh	nt:
Address:		Apartment #:	
City:	State:	Zip:	
Phone Number:	Alternate Phone:	Sex: 🗌 Male 🗌 Fe	emale
Provider Information			
Provider's Name:	Provider ID Number:		
Address:	City:	State: Zip:	
Suite Number:	Building Number:		
Phone Number:	Fax number:		
Provider's Specialty:			
Medication Information			
Medication:	Quantity:	ICD9 Code:	
Directions:	Diagnosis:	Refills:	
Physician Signature**:		DAW (Initial here):	
Physician Signature **: By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.			
Medication Instructions			
Has the patient been instructed on how to Self	-Administer?	□Yes □No	
Is this medication a New Start?		Yes No	
If NO please provide the following:	Initiation Date: / /	Date of Last Dose: /	/
**Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed			
Delivery Instructions			
 Note: Delivery coordination requires a "Physician Signature" above <u>and</u> complete "Provider Information" <u>and</u> "Patient Information" Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery 			
Ship to: Physician's Office Datient's Address Date medication is needed: / /			
	Self Administered 🔲 LTC 🗌] Physician's Office	

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