HEALTHY U MEDICAID

# PRIOR AUTHORIZATION REQUEST FORM

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

| Member Information | Prescriber Information |
|---|---|
| Member Name: | Prescriber Name and Specialty: |
| Member ID#: | Prescriber NPI#: |
| Member Date of Birth: | Prescriber Office Phone: |
| Member Phone: | Prescriber Secure Fax: |
| Member Drug Allergies: | Prescriber Office Contact: |

**Diagnosis and Medical Information**

| | |
|---|---|
| Drug Name and Strength Requested: | Diagnosis & ICD Code: |
| Dosing Instructions: | Quantity per 30 Days: |

| Questions | Yes | No |
|---|---|---|
| 1. Will the requested medication be administered in the provider's office or clinic and billed under the medical benefit ('buy-and-bill')? | ☐ | ☐ |
| 2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy. | ☐ | ☐ |

**Previous Formulary Trial(s)**

| Drug Name/Strength Dosage | Date(s) and Duration of Trial | Treatment Outcome |
|---|---|---|
| | | |
| | | |
| | | |

**Request Rationale**

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

_____

_____

_____

| | |
|---|---|
| Prescriber Signature: | Date: |

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