Medical Injectable Drug Prior Authorization Request Form

Non-contracted providers fill out this form to obtain authorization under the **medical benefit** from UCare before administering and billing UCare for the drug.

Please complete all applicable fields and FAX TO Clinical Services: 612-884-2300
Or mail to UCare, Attn: Clinical Services, P.O. Box 52, Minneapolis, MN 55440-0052

Request Date: _____

Member Information

Member Name: _____ Member DOB: _____
UCare Member ID#_____PMI (if applicable):_____
Member Address: _____
City, State, ZIP: _____
Best Contact Number: _____

Prescriber/Ordering Clinic Information

Name of Requesting Clinic: _____
Clinic Point of Contact Name (POC): _____
POC Phone#:_____Clinic POC fax#:_____
Ordering Prescriber Name: _____ NPI: _____
Specialty: _____Ordering MD Phone:_____
Location for drug administration (name of clinic, facility) and address/phone/fax:
_____
_____
NPI for location/facility administering drug: _____
Billing Provider Information (if different than location for drug administration):
NPI: _____Address:_____
_____

Drug Information/ Clinical information

Drug Requested:_____Number of Units Requested:_____
HCPCS Procedure Code: _____NDC No:_____
Member Height:_____ Member Weight:_____
Duration of Therapy Expected: _____ Authorization Start Date:_____
Is member currently being treated with the drug requested? Yes ☐ No ☐
Date started: _____
If yes, does prescriber attest the patient has had a response to treatment? Yes ☐ No ☐
Diagnosis Related to Drug Request: _____
ICD-10 code(s):_____
If applicable, please list any medications that will be used in combination with the request product to treat the same condition: _____
_____
List previous therapies tried: _____
_____