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 for the drug.

_____ Check here if this is a pre-determination request for a drug that does **not** have a coverage policy. Pre-determination requests are only accepted and reviewed for Medicare members. Request Date

Request Date: _____ Request Urgency: Standard _____ Expedited _____

Fax the completed form and clinical documentation to UCare at: 612-617-3948.

Member Information	Member Name: _____ Member DOB: _____ UCare Member ID#: _____ PMI (if applicable): _____ Member Address: _____ City, State, ZIP: _____ Contact Phone Number: _____
Prescriber/Ordering Clinic Information	Name of Requesting Clinic: _____ Clinic Point of Contact Name (POC): _____ POC Phone: _____ POC Fax: _____ Ordering Prescriber Name: _____ NPI: _____ Specialty: _____ Ordering MD Phone:_____ Are you requesting a network exception? Yes ____ No____ Location of 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 requested product to treat the same condition: _____ _____ List previous therapies tried: _____ _____