# Medical Injectable Drug Prior Authorization and Pre-Determination Request Form

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

_____ Check here if this is a pre-determination request for a drug that does **not** have a coverage policy.

**Please complete all applicable fields and fax to UCare at: 612-617-3948.** Or mail to UCare, Attn: Pharmacy, P.O. Box 52, Minneapolis, MN 55440

**Request Date:** ________________________

| Section | Fields |
|---|---|
| Member Information | Member Name: ____________________________________ Member DOB: __________________<br>UCare Member ID#: ___________________________ PMI (if applicable): ____________________<br>Member Address: _____________________________________________________________<br>City, State, ZIP: _______________________________________________________________<br>Contact Phone Number: __________________________________________________________ |
| Prescriber/Ordering Clinic Information | Name of Requesting Clinic: _____________________________________________________<br>Clinic Point of Contact Name (POC): _____________________________________________<br>POC Phone: _____________________________ POC Fax: ________________________________<br>Ordering Prescriber Name: _______________________________ NPI: _______________________<br>Specialty: ___________________________ Ordering MD Phone:_____________________________<br>Is this request for a MultiPlan provider? Yes ____ No____<br>Location of drug administration (name of clinic/facility and address):<br>_____________________________________________________________________________<br>Phone: ____________________________________ Fax: ___________________________________<br>NPI for location/facility administering drug: _________________________<br>Billing Provider Information (if different than location for drug administration):<br>NPI: _____________________ Address: _____________________________________________ |
| Drug Information/ Clinical information | Drug Requested: _____________________________ Number of Units Requested:______________<br>HCPCS Procedure Code: ________________________ NDC No:_______________________________<br>Member Height: ______________________________ Member Weight:__________________________<br>Duration of Therapy Expected: ________________ Authorization Start Date:_________________<br>Is member currently being treated with the drug requested? Yes ____ No____<br>Date started: ____________________<br>If yes, does prescriber attest the patient has had a response to treatment? Yes ____ No ____<br>Diagnosis Related to Drug Request: _____________________________________________<br>ICD-10 code(s): ________________________________________________________________<br>If applicable, please list any medications that will be used in combination with the requested product to treat the same condition: _________________________________________________<br>_____________________________________________________________________________<br>List previous therapies tried: ____________________________________________________<br>_____________________________________________________________________________ |