RARE DISEASE PRIOR AUTHORIZATION FORM

FYI**:** Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request.

Fax form and relevant clinical documentation to: 612-884-2499 or 1-866-610-7215

For questions, call: 612-676-3300 or 1-888-531-1493

E-Mail: HCM_Fax@ucare.org

UCare's Secure E-mail Site

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	

UCARE PLAN:	
PMAP	MSHO
MinnesotaCare	UCare Connect + Medicare
MSC+	UCare Individual & Family Plan
UCare Connect	

ORDERING PROVIDER INFORMATION:		
Ordering Provider Name:		
Clinic Name:	NPI Number:	
Clinic Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING PROVIDER INFORMATION:		
Servicing Provider Name:		
NPI Number:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email:		

CONTACT PERSON FOR QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

SERVICE PROCEDURE REQUESTED:
Date(s) of Service:
Test Name(s):

CPT CODE(S):

ICD-10 DIAGNOSIS CODE(S):

Total Page(s) Faxed:			

REASON FOR REQUEST:

UCare Prior Authorization Requirement
Benefit Exception
Network Exception

Has this member been diagnosed with a disease or condition that affects fewer than 200,000 persons in the U.S. and is chronic, serious, life altering, or life-threatening?

Yes No

Has this member been diagnosed with a disease or condition on the NIH Genetic Rare Disease List?

Yes No

Has this member been prescribed a drug for treatment designed as a drug for a rare disease or condition on FDA Orphan Drugs List?

Yes No

Are services to monitor and/ or treat a rare disease or condition in progress with a non-network provider?

Yes No

Does service or drug require prior authorization?

Yes No

Please note that written documentation from the medical record, including photos in some cases, supporting the procedure must be submitted for all requests. Failure to do so may result in a delay of the decision. Unless this request is for genetic related testing, do not provide any genetic information. Genetic information includes any family medical history or information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the patient may be at risk.

CRITERIA FOR RARE DISEASE: (PLEASE INCLUDE CLINICAL NOTES)

The Minnesota (MN) Rare Disease Access Mandate is a law that aims to improve care for the rare disease community in Minnesota.

Effective January 1, 2024, UCare will comply with the MN Rare Disease Mandate [Minn. Stat. § 62Q.451] ensuring that no health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring and treatment of a rare disease or condition.

"Rare disease or condition" means a disease or condition:

- Affecting fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening
- Affecting more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb FDA Orphan Drugs List
- labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health

Or for which an enrollee:

- has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint
- has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement
- had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

Additional information that may support medical necessity:

I certify that the above criteria are met as supported in the attached medical records. I also attest that this patient/ member has given informed consent for the requested testing and that the results of this testing will be used to directly impact the management of care.

Signature of Ordering Clinician: ____ Date: ___________________