MEDICATION PRIOR AUTHORIZATION REQUEST FORM
University Health Plans, Inc., New Jersey
(Do Not Use This Form for Biopharmaceutical Products*)

FAX this completed form to 866-399-0929

OR Mail requests to: US Script PA Dept. / 2425 West Shaw Avenue / Fresno, CA 93711
Call 800-460-8988 to request a 72-hour supply of medication.

I. Provider Information		II. Member Information
Prescriber name (print):		Member name:
Prescriber Specialty:		UHP ID # (11 digits):
Fax:	Phone:	Date of Birth:
Office Contact Name:		Medication allergies:

III. Drug Information *(One drug request per form)*

Drug name and strength:	Dosage form:	Dosage interval (sig):	Qty per Day:
Diagnosis relevant to ***this*** request:			
Expected length of therapy:			

Medication History for this Diagnosis

A. Is member currently treated on this medication?
☐ yes; How Long?_____ [go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
☐ yes [go to item C] ☐ no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	**Dates of Therapy**	**Reason for Discontinuation**
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The **University Health Plan, Inc. Preferred Drug List (PDL)** is available on the **University Health Plan, Inc.** website at **www.uhpnet.com.**

IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Requests for prior authorization (PA) must include member name, ID#, and drug name. **Incomplete forms will delay processing**. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

***Contact Caremark at 800-237-2767 for Biopharmaceutical Products.**