SELECT HEALTH

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and submit your request via fax to Select Health at 801-650-3279. Call 800-538-5038 if you have questions about this form

As of January 1, 2020, no prior authorization requirements may be imposed by a carrier for any FDA-approved prescription medication on its formulary which is approved to treat substance use disorders.

☐ **Urgent** [1]	☐ **Non-Urgent**	
Requested Drug Name:		
Is this drug intended to treat opioid dependence?	**Yes** ☐	**No** ☐
If **Yes,** is this a first request within a 12-month period for prior authorization for this drug? *** If Yes, prior authorization is not required for a 5-day supply of any FDA-approved drug for the treatment of opioid dependence and there is no need to complete this form.** *** If No, as of January 1, 2020, a prior authorization is not required for prescription medications on the carrier's formulary and there is no need to complete this form.**	**Yes *** ☐	**No *** ☐

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit: ☐ New Request ☐ Reauthorization

Patient Diagnosis and ICD Diagnostic Code(s):		
Drug(s) Requested (with J-Code, if applicable):		
Strength/Route/Frequency:		
Unit/Volume of Named Drug(s):		
Start Date and Length of Therapy:		
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:		
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response:		
For use in clinical trial? (If yes, provide trial name and registration number):		
Drug Name (Brand Name and Scientific Name)/Strength:		
Dose:	Route:	Frequency:
Quantity:	Number of Refills:	
Product will be delivered to: ☐ Patient's Home	☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:		Date:
Dispensing Pharmacy Name and Phone Number:		

☐ **Approved**	☐ **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:	

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.