PRIOR AUTHORIZATION REQUEST
Global PA Criteria

PATIENT: Name______________________________
Address:___________________________
City, State, Zip______________________
D.O.B.______________________________
Member ID: _________________________

Prescriber: Name______________________________
Address____________________________
City, State, Zip______________________
Phone ______________________
Fax_______________________
NPI ______________________

Medication Requested: ___________ Qty Requested: ___________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Please provide the patient's diagnosis or indication, current weight in kg, prescribed strength and dose per mg, frequency, route of administration (for example, oral, topical, subcutaneous, intravenous, etc.), and number of courses requested (if applicable). Indicate if the dose is adjusted for the patient's condition or other patient specific considerations.

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2. ❑ Yes ❑No Is this a RENEWAL request for a previous authorization of this medication? ***If "Yes" please answer questions 3 – 4 & 11. If "No" please answer questions 5–11.***
3. ❑ Yes ❑No Is the patient responding to therapy with the requested medication?
4. ❑ Yes ❑No Is this a request for MAINTENANCE therapy?
5. Is this request for a brand or generic medication?
   ❑Brand → ***please answer questions 6–11***
   ❑Generic → ***please answer questions 9–11***
6. ❑ Yes ❑No Did the patient experience intolerance or adverse side effect to the generic formulations made by TWO different manufacturers?
7. ❑ Yes ❑No Did the patient experience a treatment failure with a trial of generic formulations made by TWO different manufacturers?

The MedWatch form (Form FDA 3500) is available at fda.gov. Search "ucm163919" in the search bar in the upper right corner of the home page.

8. ❑ Yes ❑ No Has a MedWatch Form 3500 been completed and submitted with this request?

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If you have any questions, call: 800-753-2851

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9. Please document ALL of the other medications the patient has tried for their condition. ***For each medication, include whether it is current or past treatment, and the DATES and DURATION of therapy with each of these agents.***

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10. Please document ALL of the medications that are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. ***The type of contraindication must be included for each medication (such as drug allergy or serious drug interaction).***

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Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851