UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
Fax: 303-602-2081 or Call 303-602-2070 or 877-357-0963 with questions.
For **after-hours urgent requests**, please call the MedImpact help desk at 800-788-2949

	Urgent [1] **Non-Urgent**
	Requested Drug Name:

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:
Prescription Date:	Prescriber DEA:
	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: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]		
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:	

Prescriber Notice:

By checking this box, I agree to receive prior authorization approval notification via facsimile to the Prescriber fax listed above.

1. A request for prior authorization 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 subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request