

# NEW HAMPSHIRE UNIFORM PRIOR AUTHORIZATION FORM

## PRESCRIPTION DRUG REQUESTS

### A. Destination of Request *(This section is to be completed by insurers/PBMs/UREs prior to making form available)*

Insurer or Pharmacy Benefit Manager (PBM) Name: OptumRx on behalf of Harvard Pilgrim Health Care	
Phone #: 1-855-258-1561	Fax #: 1-844-403-1029
Electronic Prior Authorization Webpage:	

*\*Insurers and PBMs are not permitted to require information in addition to that requested below. Certain insurers may not require all of the information requested on this form.*

### B. Type of Request

Check one: <input type="checkbox"/> Initial Request <input type="checkbox"/> Continuation/Renewal Request	
Check if Expedited Review/Urgent Request: <input type="checkbox"/>	<p><b>By initialing here, I, as the treating provider, attest to the fact that this request meets the URAC (Utilization Review Accreditation Commission) health accreditation standards for urgent care</b> in that adherence to the standard timelines: a) could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or b) would subject the patient to severe pain that cannot be adequately managed without the treatment being requested.</p>

### C. Patient Information

Patient's Full Name (including Jr, Sr, III, etc):	DOB:
Harvard Pilgrim Health Care Insurance ID#:	Group #:

### D. Prescriber Information

Prescribing Provider:	Phone #:
Address:	
Secure Fax #:	Specialty:
Prescribing Provider NPI #:	Prescribing Provider DEA #:
Prescriber Point of Contact (POC) Name (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
<b>Prescribing Provider or Authorized Designee</b>	
<b>Signature:</b>	<b>Date:</b>

### E. Diagnosis and Medication Information

Primary Diagnosis Related to Medication Request:	
Medication Requested:	Strength:
Quantity:	Dosing Schedule:
Length of Therapy:	Date of Prescription:
Is the patient currently being treated with the drug requested? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, date started:	

Dispense as Written (DAW) Specified?  Yes  No      If yes, rationale for DAW:

Alternate therapies contraindicated or previously tried (please provide more information in Section F)

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change (specify anticipated significant adverse clinical outcome in space below)

Medical need for increase in current dosage, strength and / or frequency (specify in space below: (1) dosage, strength(s) and / or frequency(s) tried; (2) medical reason)

Absence of appropriate formulation or indication of the drug (specify in space below)

Other (specify in space below)

Required Explanation from Above:

**F. Additional Clinical Information (provide as relevant to the request)**

Drug Allergies:					
Height:		Weight:			
Relevant Lab Values/Test Results (Providers may attach additional pages or documentation as needed)					
Lab/Test Name and Results	Date	Lab/Test Name and Results	Date		
Previous Medications and/or Non-Pharmacologic Therapies Tried/Failed (Providers may attach additional pages or documentation as needed)					
Medication/Therapy Name	Strength (as relevant)	Dosing Schedule (as relevant)	Date Prescribed/ Started	Date Stopped	Description of Adverse Reaction or Failure
List any contraindications to alternate therapies (Providers may attach additional pages or documentation as needed)					
Therapy			Description of Contraindication		
Additional information (prescribing providers may provide additional information to support this request):					
(Providers may attach additional pages or documentation as needed)					

**G. Confidentiality Notice**

This form and the documents accompanying it contain confidential health information that is legally privileged. This information is intended only for use by the entity listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

**Providers should consult the health plan’s coverage policies, member benefits, and medical necessity guidelines to complete this form.**

**Providers may attach any additional data or documentation relevant to this request.**