



PHARMACY SERVICES
Uniform Medical Plan
Prior Authorization (PA) Request Form
PHONE (888) 361-1611
FAX (800) 207-8235

DATE: _____ **SENDER'S INITIALS:** _____

PATIENT INFORMATION

ENROLLEE NAME: _____ **DATE OF BIRTH:** _____

SUBSCRIBER ID #: _____

PHYSICIAN INFORMATION

NAME: _____

PHONE: _____ **FAX:** _____

CONTACT NAME: _____

MEDICATION INFORMATION

MEDICATION: _____

STRENGTH: _____ **FREQUENCY:** _____

ICD-9 CODE: _____

**PREVIOUS MEDICATIONS TRIED,
INCLUDING DOSE AND
DURATION OF TRIAL:** _____

CIRCUMSTANCES FOR MEDICAL NECESSITY: _____



Prior Authorization (PA) Request Form (continued)

ADDITIONAL QUESTIONS