Illinois Uniform Electronic Prior Authorization Form For Prescription Benefits

Providers complete this form in its entirety and fax to the Prior Authorization Team at 1-866-414-3453

☐ **Standard Review Request**

☐ **Expedited Review Request:** *I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*

Provider's Direct Contact Phone Number ( )_____-_____ Initials: _____

A) Reason for Request

☐ Initial Authorization Request ☐ Renewal Request ☐ DAW

Note: This form does not apply to requests for medical exceptions under Sections 25(a)(3) or 45.1 of the Managed Care Reform and Patient Rights Act [215 ILCS 134]. Please contact the patient's health plan to obtain the appropriate forms.

B) Patient Demographics

Is patient hospitalized: ◯ Yes ◯ No

Patient Name: _____ DOB: _____

Patient Street Address: _____ Unit/Apt: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: ( )_____-_____ Sex: _____

Patient Health Plan ID: _____

Patient Health Plan Group # (if applicable): _____

C) Prescribing Provider Information

Provider Name: _____ NPI: _____ Specialty: _____

DEA (required for controlled substance requests only): _____

Contact Name: _____ Contact Phone: ( )_____-_____

Contact Street Address: _____ Suite/Rm: _____

City: _____ State: _____ ZIP Code: _____

Contact Email (optional): _____ Contact Fax: ( )_____-_____

Health Plan Provider ID (if accessible): _____

D) Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: ( )_____-_____

E) Requested Prescription Drug Information

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Duration: _____

Diagnosis (specific): _____

Diagnosis ICD#: _____

Place of infusion / injection (if applicable): _____

Facility Provider ID / NPI: _____

Has the patient already started the medication? ◯ Yes ◯ No If so, when? _____

Ingredients within drug: _____

F) Rationale for Prior Authorization (e.g., history of present illness, past medical history, current medications, etc.; you may also attach chart notes to support the request if you believe it will assist in the review process)

_____

_____

_____

G) Failed/Contraindicated Therapies (if applicable in the provider's opinion)

Drug Name	Strength	Dosing Schedule	Duration	Adverse Event / Specific Failure

H) Other Pertinent Information (Optional: To be filled out if other information in the prescribing provider's professional opinion is necessary, such as relevant diagnostic labs, measures, response to treatment, etc.)

_____

_____

_____

J) Representation

I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Prescribing Provider's Name: _____

Prescribing Provider's Signature: _____

Date: _____

****For Health Plan Use Only****

Request Date: _____ Limitation of Benefits (LOB): _____

Approved: ◯ Denied: ◯

Approved by (name and credentials) Denied by (name and credentials)

_____ _____

Reviewed by (name and credentials)

_____

Effective Date:_____Reason for Denial: _____

Additional comments, if any: _____

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