Illinois Uniform Electronic Prior Authorization Form For Prescription Benefits

Providers complete this form in its entirety and fax to the Prior Authorization Team at 1-858-790-7100

☐ **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)

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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.)

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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)

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Effective Date:____________________Reason for Denial: ______________________________________

Additional comments, if any: ____

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