**CarelonRx in Colorado**
**UNIFORM PHARMACY PRIOR AUTHORIZATION/STEP THERAPY EXCEPTION REQUEST FORM CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete this form in its entirety and fax to the Prior Authorization Benefits Center at 844-521-6939.**

| | |
|---|---|
| ☐ **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<br>☐ Step Therapy Exception | |
| Is this drug intended to treat opioid dependence? | ☐ Yes | ☐ No |
| If yes, is this the first request for prior authorization for this drug?<br>*If yes, prior authorization is not required. No need to complete this form. | ☐ Yes | ☐ No |
| If No, what was the date of the first request?<br>*If greater than twelve (12) months since the first request, prior authorization request form is not required. | Date: _____ | |
| 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: |

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| | | | |
|---|---|---|---|
| | 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: | | |
| | 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: | | |

1. A request for prior authorization that 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, could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request, or is a prior authorization request for medication-assisted treatment for substance abuse disorders.

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