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: CarelonRx	
Phone #: 833-293-0659, option 1	Fax #: 844-474-3355
Electronic Prior Authorization Webpage: https://www.covermymeds.com/main/prior-authorization-forms Electronic Prior Authorization Webpage: https://providerportal.surescripts.net/providerportal	

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: ☐ Initial Request ☐ Continuation/Renewal Request	
Check if Expedited Review/Urgent Request: ☐	_____ **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** 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.

C. Patient Information

Patient's Full Name (including Jr, Sr, III, etc):	DOB:
Member 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):	
Prescribing Provider or Authorized Designee **Signature**:	**Date**:

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? ☐ Yes ☐ No	If yes, date started:

 (continued on next page)

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

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.

Instruction Sheet for New Hampshire Uniform Prior Authorization Form for Prescription Drug Requests

A. Destination of Request - Insurer or pharmacy benefits manager (PBM) will pre-populate Section A prior to making the form available on its website.

- Insurer or Pharmacy Benefit Manager Name – Company to which the form shall be submitted
- Phone # - Phone number for contacting the company regarding prior authorization
- Fax # – Secure fax number for submitting the request
- Electronic Prior Authorization Webpage - Webpage for submitting prior authorization requests electronically, as applicable

Insurers and PBMs are not permitted to require information in addition to that requested on this form. Certain insurers may not require all of the information requested on this form. Prescribing providers can consult the health plan's coverage policies, member benefits, and medical necessity guidelines for details regarding required information. Prescribing providers may attach any additional information or documentation to support the request.

B. Type of Request – Indicate the type of request being submitted.

- Indicate whether the request is being made for the first time or is a request for continuation or renewal of an existing prior authorization
- Indicate if **expedited review** is being requested; **if so, the treating provider should initial to attest** that the request meets the URAC standards for urgent care (applying 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) in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested)

C. Patient Information – Provide identifying information about the patient for whom the drug is being requested.

- Patient's Full Name – First, middle and last name (or middle initial) and any suffix
- DOB – Patient's month, day and year of birth
- Member ID # – Patient's insurer or PBM member identification number (see member card)
- Group # – Patient's insurer or PBM group number (see member card)

D. Prescriber Information - Provide identifying and contact information for the provider prescribing the medication being requested.

- Prescribing Provider - Name of provider prescribing the medication being requested
- Phone # - Phone number for contacting the prescribing provider regarding the prior authorization request
- Address - Mailing address for sending prior authorization determinations to the prescribing provider
- Secure Fax # - Secure fax number for sending prior authorization determinations to the prescribing provider
- Specialty—Prescribing provider's specialty (if multiple, include the specialty relevant to the request)
- Prescribing Provider NPI # - Prescribing provider's National Provider Identifier number
- Prescribing Provider DEA # – The number assigned to the prescribing provider by the U.S. Drug Enforcement Administration allowing the provider to write prescriptions for controlled substances
- Prescriber Point of Contact (POC) Name – A person in the provider's office (if different than the prescribing provider) that can be contacted regarding the prior authorization request
- POC Phone # – Phone number for contacting the POC regarding the prior authorization request
- POC Secure Fax # – Secure fax number for sending prior authorization determinations to the POC
- POC Email – Email address for contacting the POC regarding the prior authorization request (not required)
- Prescribing Provider or Authorized Designee Signature **I** Date – Form must be signed and dated by the prescribing provider or an authorized designee

E. Diagnosis and Medication Information – Provide information about the patient's diagnosis and the medication being requested, including details specific to the patient's prescription.

- Primary Diagnosis Related to the Medication Request – Patient's diagnosis related to which the medication is being requested (ICD Codes are not required)
- Medication Requested - Medication name
- Strength - Medication strength being prescribed
- Quantity - Quantity of the medication being prescribed
- Dosing Schedule - Frequency of administration of medication being prescribed
- Length of Therapy - Duration prescribed for medication
- Date of Prescription - Date medication was prescribed
- Current Treatment – Is this an ongoing treatment? If so, date it was started
- Dispense as Written Specified? – Does the prescribing provider request that an alternate version or medication not be substituted for the requested medication? If yes, provide rationale by checking the appropriate box and providing additional information as required

F. Additional Clinical Information – Provide information about the patient's health and treatment as it is relevant to the medication being requested.

- Drug Allergies - Patient's current drug allergies
- Height - Patient's current height
- Weight - Patient's current weight
- Relevant Lab Values / Test Results – The name, results, and date of any laboratory or other tests that are relevant to the request
- Previous Medications and / or Non-Pharmacologic Therapies Tried / Failed – Any alternate prescription drug or non-pharmacologic therapies tried by the patient for the same purpose for which the requested medication is being prescribed; include (as relevant) medication or therapy name, strength, dosing schedule prescribed, date prescribed / started, date stopped, and description of adverse reaction or failure
- Contraindications to Alternate Therapies – The name of any alternate therapy that cannot be used because it may be harmful and a description of the contraindication(s)
- Additional Information - The prescribing provider may provide any additional information to support the request