Health Plans

Indiana University Health Plans
Pharmacy Benefits Management
Commercial Phone: 866.822.6504
Exchange Phone: 855.859.1719
Fax: 855.397.8762

GENERAL AUTHORIZATION FORM
Prior Authorization, Step Therapy & Quantity Limit Exception

□ Standard Request □ Expedited Request*	* If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name (First, Middle Initial, Last):		Prescriber Name:	
DOB (mm/dd/yyyy):	Weight:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Drug Allergies (including reaction):		Office Contact Name:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
□ New medication □ Continuation of therapy*	Start Date:	□ Generic □ Brand Necessary*

* If this is continuation of therapy, please provide **CHART DOCUMENTATION** showing improvement with therapy	*Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

Billing Information

□ Billed under **PHARMACY** benefit *Delivered to the member or provider for administration*	□ Billed under **MEDICAL** benefit *Billed by the provider/facility and not self-administered*	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home
Quantity Dispensed:	J- Code (MUST BE PROVIDED):	
Day Supply:	Dates of Service:	
Pharmacy Name and Phone:	Total VISITS: / Total UNITS:	

Clinical Information

Diagnosis (*include ICD-10 Code*):	Date Diagnosed:

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please continue to the second page to complete this request form.
Please provide any additional information which should be considered in the space below:

Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Please attach any applicable CHART DOCUMENTATION and LABS with this request.