

Prior Authorization Form: Medical Injectables

This prior authorization (PA) form and PA criteria is available at <https://provider.unicare.com>. If the following information is not complete, correct or legible, the PA process may be delayed. Use one form per member. Fax this form to **1-844-487-9290**. For telephone PA requests or questions, please call **1-877-375-6185**.

Please allow UniCare Health Plan of West Virginia, Inc. at least 24 hours to review this request.

Member information		
Last name:	First name:	
Member ID number:	DOB:	
Required		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: _____ Weight: _____	
Member's place of residence: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility		
Administration location: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Outpatient facility		
Requesting provider <input type="checkbox"/> Contracted <input type="checkbox"/> Noncontracted (complete the below box if individual provider is <i>not</i> billing)		
Last name:	First name:	Specialty:
NPI number:		Tax ID number:
Office contact name:	Office phone:	Office fax:
Address:		City, state and ZIP code:
Servicing provider <input type="checkbox"/> Contracted <input type="checkbox"/> Noncontracted (complete the below box if individual provider is billing)		
Last name:	First name:	Specialty:
NPI number:		Tax ID number:
Office contact name:	Office phone:	Office fax:
Address:		City, state and ZIP code:
Servicing facility <input type="checkbox"/> Contracted <input type="checkbox"/> Noncontracted (complete the below box if the facility is billing)		
Facility name:		
NPI number:		Tax ID number:
Facility contact name:	Facility phone:	Facility fax:
Address:		City, state and ZIP code:

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Medical information					
Facility name:					
Drug name and strength requested:					
SIG (dose, frequency and duration):					
HCPCS billing code:			ICD code (required):		
Diagnosis and/or indication:					
Has member tried other medications to treat this condition? <input type="checkbox"/> Yes, provide this information in the area below. You may be asked to provide supporting documentation such as copies of medical records, office notes or complete <i>FDA MedWatch</i> form. <input type="checkbox"/> No, explain why not:					
Drug(s) name and strength:		Date range of use:		SIG (dose and frequency):	
Did member experience any of the below? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response or other in the space provided below.					
Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:					
List all current medications, including dose and frequency:					
Other pertinent information:					
Diagnostic studies and/or laboratory tests performed					
(List all tests done within the past 30 days that are related to diagnosis for medication requested.)					
Labs:			Diagnostic tests:		
Test	Date	Result	Test	Date	Result

Prescriber signature (required): _____
 Date: _____

(By providing a signature, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission or concealment of material may be subject to civil or criminal liability.)