UniCare Health Plan of West Virginia, Inc.
Mountain Health Trust

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.

Requests may be submitted via the Interactive Care Reviewer (ICR) at **availity.com**.* Please complete **all** required fields, including TIN.

Use one form per member. Fax this form to **844-487-9290**. For telephone PA requests or questions, please call **877-375-6185**.

Member information		
Last name:	First name:	
Member ID number:	DOB:	
Required		
Gender: Male ☐ Female ☐	Height:_____Weight:_____	
Member's place of residence: Home ☐ Nursing facility ☐		
Administration location: Home ☐ Office ☐ Outpatient facility ☐		
Requesting provider ☐ **Contracted** ☐ **Noncontracted** **(Complete the below box if individual provider is *not* 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 ☐ **Contracted** ☐ **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 ☐ **Contracted** ☐ **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:	

Continued on page 2 (required)

* Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc.

Medical information		
Drug name and strength requested:		
SIG (dose, frequency and duration):		
HCPCS billing code(s):	ICD code (required):	
Diagnosis and/or indication:		
Has member tried other medications to treat this condition? ☐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 *FDA MedWatch* form. ☐No, explain why not:		
Drug(s) name and strength:	Date range of use:	SIG (dose and frequency):
Did member experience any of the below? ☐Adverse reaction ☐Inadequate response ☐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: _____

Please attach any pertinent medical records required for review.

(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.)