

# UPPER PENINSULA HEALTH PLAN

## REQUEST FOR PRIOR AUTHORIZATION (ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

### PRESCRIBING PHYSICIAN:

### BENEFICIARY:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

First Last

First Last

Direct Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Member ID #: \_\_\_\_\_

Fax #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_ - \_\_ - \_\_\_\_\_

Physician specialty: \_\_\_\_\_

Sex:  Female  Male

Name and title of person completing form (please print): \_\_\_\_\_

Drug name:      Strength:      Administration Schedule:      Length of Therapy:      Quantity Requested:

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

Patient's diagnosis for use of this medication: \_\_\_\_\_

1. Previous history of a medical condition, allergies, or other pertinent medical information that necessitates the use of this medication:  
\_\_\_\_\_

2. Has the patient been seen by any other provider for this condition?  Yes  No  
If so, what was the prescriber's specialty? \_\_\_\_\_

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
_____	_____	__/__/____
_____	_____	__/__/____
_____	_____	__/__/____

4. Pertinent laboratory test or procedure (if applicable):

Procedure:	Findings:	Date:
_____	_____	__/__/____
_____	_____	__/__/____
_____	_____	__/__/____

5. Other Information:

#### 4-D Pharmacy Use Only

Date: \_\_/\_\_/\_\_\_\_

Approved

Changed

Denied

GCN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Comments:

Submit Requests to:

4-D Pharmacy Management Systems

P.O. Box 72098

Berkley, Mi 48072

Phone: (888) 274-2031 Fax: (248) 540-9811