UPPER PENINSULA HEALTH PLAN

REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY.)

PRESCRIBING PHYSICIAN:

Name:_____
First **Last**
Direct Phone #: (_ _ _) - _ _ _ - _ _ _ _
Fax #: (_ _ _) - _ _ _ - _ _ _ _
Physician specialty: _____

BENEFICIARY:

Name:_____
First **Last**
Member ID #: _____
Date of Birth: _ _ - _ _ - _ _ _ _
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:**

4D Pharmacy Use Only

Date: _ _ / _ _ / _ _ _ _ ☐ **Approved** ☐ **Changed** ☐ **Denied**

GCN: _____/_____/_____

Comments:

Submit Requests to:

4D Pharmacy Management Systems
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Birmingham, MI 48009
Telephone: (888) 274-2031
Fax: (248) 540-9811