



1650 Spring Gate Lane
 Las Vegas, NV 89134
 Tel: 888-869-4600

Please Note: Medical-Necessity Prior Authorization may be utilized to override both formulary coverage and benefit-design restrictions. They are issued at the full discretion of the benefit manager.

UPPER PENINSULA HEALTH PLAN

PRIOR-AUTHORIZATION FORM COMPLETE AND FAX TO CATALYST Rx AT 888-852-1832.

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-9	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			
Has the patient been seen by any other provider for this condition?			
ESR: _____ CRP: _____ # Joints: _____ % BSA: _____ Sex: _____ Height: _____ Weight: _____ BMI: _____ HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____ Dialysis: _____ Long-Term-Care Facility: _____ Self Injecting: _____ Stimulation test: _____ / _____ Growth velocity: _____ # Chemotherapy cycles/month: _____ Mini-Mental Status Test: _____ Baseline free testosterone/total testosterone: _____ / _____ HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark <i>Urgent</i> when standard review time would seriously harm the member's life or health or ability to regain maximum function. <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	

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