



**UPHP Medicaid – Medical
Pharmacy Prior Authorization (PA)
Request Form Fax completed form:
906-225-4516**

WWW.UPHP.COM

Date of Request:			
Member First Name:		Member Last Name:	
Member Date of Birth (MM/DD/YYYY):		Member ID Number:	
Member Weight (kg):		Height (cm):	
Diagnosis:		ICD 10:	
Requesting Provider Name:		Office Contact Name:	
Phone Number:		Fax Number:	
NPI Number:			
Ancillary/Service Provider Name*:		Ancillary/Service Provider Address:	
Ancillary/Service Provider Phone Number:		Ancillary/Service Fax Provider Number:	
Ancillary/Service Provider TIN:		Ancillary/Service Provider NPI:	
Drug Name:		J Code:	
Dose (mg, g, unit, etc):		Frequency (days, weeks, months):	
Route (IV, SQ, etc):		Start Date of Requested Medication:	
Please attach supporting documentation for this request. Medication specific criteria can be found at www.uphp.com			

Please process this request:

- Standard:** decisions within 14 calendar days
- Urgent:** decisions within 72 hours; request that if waiting for a decision under standard timeframes would place the member’s life, health or ability to regain maximum function in serious jeopardy. If request is outside of this definition, it should be submitted as Standard/Routine.

*Please note that if the ancillary/service provider is not in the UPHP provider network and there is not current out-of-network authorization, this request will be denied. To verify if a provider is in the UPHP network, please review the website at www.uphp.com. To verify if an out-of-network authorization is current please call UPHP Customer Service at: 800-835-2556.