USscript
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HEALTH REPUBLIC INSURANCE

Prior Authorization Request Form for Specialty Prescription Medications

Type of Specialty Medication Request. Please select one option
Note: If requesting a self-injectable, fax completed form to (866)339-0929; Mail requests to: US Script PA Dept/2425 West Shaw Ave/Fresno, CA 93711

☐ **Self-Injectable and home infusions	Fax Completed form to USS at 866-339-0929
☐ Buy and Bill	Call Pre-Cert Dept @ 888-990-5702 or fax to 888-790-0276
☐ Replacement (Delivered to MD office or facility)	Call Pre-Cert Dept @ 888-990-5702 or fax to 888-790-0276

Patient Name:_____
Address:_____
City_____ State:_____ Zip: _____
Home Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Patient Soc Sec #: _____ Allergies: _____
Date of Birth: ___/___/___
Sex: ☐ Male ☐ Female Weight_____ lbs kg
Height: BSA:_____m^2

Physician Name:_____
State Lic #:_____ DEA #:_____
NPI #:_____
Specialty:_____
Practice/Hospital:_____
Address:_____
City_____ State:_____ Zip: _____
MD Phone: (_____) _____ - _____
MD fax: (_____) _____ - _____
Nurse/Key Contact: _____

INSURANCE INFORMATION (Complete or Attach Copies of Cards)

Primary Insurance: _____
City: _____ State: ____
Plan #:_____
Group #:_____
Phone: (_____) _____ - _____

Second Insurance:_____
City: _____ State:___
Plan #:_____
Group #:_____
Phone: (____) _____ - _____

Rx Card (PBM):_____
PBM BIN: _____
Plan #:_____
Group #:_____
Phone: (____) _____ - _____

Cardholder First Name:_____
LastName:_____
Employer:_____
ID#:_____
Group#:_____

DIAGONSIS (Required)

What is the ICD 9 / ICD 10 code:

Medication	Strength	Directions	Quantity	Refills

PATIENT EVALUATION

1. Is the member currently treated with this medication
   ☐ Yes; (please continue to next question) No; (please move on to question #4)
2. How long has the patient been on treatment with this medication: _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐ Yes ☐ No
4. Please indicate previous treatments and outcomes

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
Note: Confirmation will also be made from member history on file when possible; prior use of preferred drugs is part of exception criteria		

5. Please state rationale for request / pertinent clinical information (Required for all prior authorizations

****NOTE: We can Not make a decision without a copy of pertinent lab results and/or current clinical progress notes and RX****