Illinois Uniform Electronic Prior Authorization Form For Prescription Benefits

Important: Please read all instructions below before completing this form.

215 ILCS 5/364.3 requires the use of a uniform electronic prior authorization form when a policy, certificate or contract requires prior authorization for prescription drug benefits. The Department of Insurance may update this form periodically. The form number and most recent revision date are displayed in the top left corner.

This form is made available for use by prescribing providers to initiate a prior authorization request with a commercial health insurance issuer ("insurer") regulated by the Illinois Department of Insurance.

"Prior authorization request" means a request for pre-approval from an insurer for a specified prescription or quantity of a prescription before the prescription is dispensed.

“Prescribing provider" has the meaning ascribed in Section 364.3 of the Illinois Insurance Code [215 ILCS 5].

“Prescription” has the meaning ascribed in Section 3(e) of the Pharmacy Practice Act [225 ILCS 85].

If, upon receipt of a completed and accurate electronic prior authorization request from a prescribing provider pursuant to the submission of this form, an insurer fails to use or accept the uniform electronic prior authorization form or fails to respond within 24 hours (if the patient has urgent medication needs), or 72 hours (if the patient has regular medication needs), then the prior authorization request shall be deemed to have been granted [215 ILCS 5/364.3(f)]. The prescribing provider should only provide its direct contact number and initials if requesting an Expedited Review Request.

The provisions of this form do not serve as a replacement for the step therapy and formulary exception requests that may require additional information and forms as provided in Sections 25(a)(3) and 45.1 of the Managed Care Reform and Patient Rights Act [215 ILCS 134]. Nothing in this form shall be construed to alter or nullify any provisions of federal or Illinois law that impose obligations on insurers, prescribing providers, or patients related to responsiveness, adjudication and/or appeals.

Prior authorization alone is not a guarantee of benefits or payment. Actual availability of benefits is always subject to other requirements of the health plan, such as limitations and exclusions, payment of premium, and eligibility at the time services are provided. The applicable terms of a patient's plan control the benefits that are available. At the time the claims are submitted, they will be reviewed in accordance with the terms of the plan.

Please refer to the plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Insurers may require additional information based on the type of prescription drug being requested that may require follow-up inquiries with the provider.

PRESCRIBING PROVIDERS: PLEASE SUBMIT THIS FORM TO THE PATIENT’S HEALTH PLAN ONLY. Please do not send forms to the Department of Insurance.

Insurer Contact and Submission Information

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

Phone: 800-285-9426 **Fax: 877-243-6930**

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PROVIDERS SUBMIT THIS FORM TO THE PATIENT'S HEALTH PLAN)

☐ Standard Review Request

☐ Expedited Review Request: I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Provider's Direct Contact Phone Number ( )_____-_____ Initials: _____

A) Reason for Request

☐ Initial Authorization Request ☐ Renewal Request ☐ DAW

Note: This form does not apply to requests for medical exceptions under Sections 25(a)(3) or 45.1 of the Managed Care Reform and Patient Rights Act [215 ILCS 134]. Please contact the patient's health plan to obtain the appropriate forms.

B) Patient Demographics

Is patient hospitalized: ◯ Yes ◯ No

Patient Name: _____ DOB: _____

Patient Street Address: _____ Unit/Apt: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: ( )_____-_____ Sex: _____

Patient Health Plan ID: _____

Patient Health Plan Group # (if applicable): _____

C) Prescribing Provider Information

Provider Name: _____ NPI: _____ Specialty: _____

DEA (required for controlled substance requests only): _____

Contact Name: _____ Contact Phone: ( )_____-_____

Contact Street Address: _____ Suite/Rm: _____

City: _____ State: _____ ZIP Code: _____

Contact Email (optional): _____ Contact Fax: ( )_____-_____

Health Plan Provider ID (if accessible): _____

D) Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: ( )_____-_____

E) Requested Prescription Drug Information

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Duration: _____

Diagnosis (specific): _____

Diagnosis ICD#: _____

Place of infusion / injection (if applicable): _____

Facility Provider ID / NPI: _____

Has the patient already started the medication? ◯ Yes ◯ No If so, when? _____

Ingredients within drug: _____

F) Rationale for Prior Authorization (e.g., history of present illness, past medical history, current medications, etc.; you may also attach chart notes to support the request if you believe it will assist in the review process)

_____

_____

_____

G) Failed/Contraindicated Therapies (if applicable in the provider's opinion)

Drug Name	Strength	Dosing Schedule	Duration	Adverse Event / Specific Failure

H) Other Pertinent Information (Optional: To be filled out if other information in the prescribing provider's professional opinion is necessary, such as relevant diagnostic labs, measures, response to treatment, etc.)

_____

_____

_____

J) Representation

I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Prescribing Provider's Name: _____

Prescribing Provider's Signature: _____

Date: _____

****For Health Plan Use Only****

Request Date: _____ Limitation of Benefits (LOB): _____

Approved: ◯ Denied: ◯

Approved by (name and credentials) Denied by (name and credentials)

_____ _____

Reviewed by (name and credentials)

_____

Effective Date:_____Reason for Denial: _____

Additional comments, if any: _____

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