

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Attn: Evidence-Based Prescription Drug Program (EBRx)

c/o UAMS College of Pharmacy

4301 W. Markham St., Slot #522

Little Rock, AR 72205

Phone: (833) 650-0475

Fax: (877) 540-9036

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| **This form is being used for:** | | |
| Check one: | ☐ Initial Request | ☐ Continuation of Therapy/Renewal Request |
| Reason for request *(check all that apply)*: ☐ Prior Authorization, Step Therapy, Formulary Exception  ☐ Quantity Exception  ☐ Specialty Drug  ☐ Other *(please specify)*: | | |
| **🗆** **By checking this box,** **I attest this is an urgent case, meaning that an expedited determination is necessary to prevent serious threat to life, limb, or eyesight; or threatens the body’s ability to regain maximum function; or is needed to manage severe pain.** | | |
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| **Pain Control for Terminal Illness** | | |
| **🗆 By checking this box, you hereby certify that this request is for pain control of a patient who is terminally ill with a life expectancy of six (6) months or less if the illness runs its normal course.** | | |

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| **Patient Information** | | |
| Patient Name: | DOB: | Gender: ☐ Male ☐ Female ☐ Unknown |
| Member ID #: | | |

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| **Prescriber Information** | | |
| Prescribing Clinician: | Phone #: | |
| Specialty: | Secure Fax #: | |
| NPI #: | DEA/xDEA: | |
| Prescriber Point of Contact Name (POC) (if different than provider): | | |
| POC Phone #: | POC Secure Fax #: | |
| POC Email (not required): | | |
| Prescribing Clinician or Authorized Representative Signature: | | |
| Print Authorized Representative’s Name: | | Date: |

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| **Medication Information** | |
| Medication Being Requested: | |
| Strength: | Quantity: |
| Dosing Schedule: | Length of Therapy: |
| Date Therapy Initiated: |  |
| Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started: | |
| If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A | |
| If yes, please describe: | |
| Dispense as Written (DAW) Specified? ☐ Yes ☐ No | |
| Rationale for DAW: | |

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| **Compound and/or Off Label Use** | |
| Is Medication a Compound? ☐ Yes ☐ No |  |
| If Medication Is a Compound, List Ingredients: | |
| For Compound or Off Label Use, include citation to peer reviewed literature: | |

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| **Patient Clinical Information** | | | | | | | |
| Primary Diagnosis Related to Medication Request: | | | | | | | |
| ICD Codes: | | | | | | | |
| Pertinent Comorbidities: | | | | | | | |
| Drug Allergies: | | | | | | | |
| Height: | | | | Weight: | | | |
| Pertinent Concurrent Medications: | | | | | | | |
| Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber Restriction | | | | | | | |
| Previous Therapies Tried/Failed: | | | | | | | |
| **Previous Therapies Tried and/or Failed** | | | | | | | |
| Drug Name | Strength | Dosing Schedule | Date Prescribed | | Date Stopped | Description of Adverse Reaction or Failure | Check if Sample |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
| Are there contraindications to alternative therapies? ☐ Yes ☐ No | | | | | | | |
| If yes, please list details: | | | | | | | |
| Were nonpharmacologic therapies tried? ☐ Yes ☐ No | | | | | | | |
| If yes, provide details: | | | | | | | |
| **Relevant Lab Values** | | | | | | | |
| Lab Name and Lab Value | Date Performed | | Lab Name and Lab Value | | | | Date Performed |
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| Additional information pertinent to this request: | | | | | | | |