UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Non-Covered State Medicaid Plan Services Request Form for Recipients *under* 21 Years Old

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:
http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

This form MUST accompany your Prior Approval request for EPSDT consideration via submission through provider portal, fax or mail. **DO NOT** send this form without an accompanying Prior Approval request. It will not be processed without a Prior Approval Request.

You may fax form to 1-866-940-7328 or call 1-855-258-1593. You may use additional sheets to supply any other information you think would be helpful.

Include evidence-based literature, if available.

I. Recipient Information: This must be completed by a physician, licensed clinician, or other provider. Name: _____

Date of Birth:_____/____/_____(*mm/dd/yyyy)* Medicaid ID Number: _____

Address:

_____

_____

_____

II. Medical Necessity: All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: _____ Provider Name: _____

NPI: _____ NPI: _____

Address: _____ Address: _____

_____ _____

_____ _____

Telephone: (____) _____-_____ Telephone: (_____) _____-_____

Fax: (____)_____-_____ Fax: (_____)_____-_____

Requested procedure,
product or service: _____ CPT/HCPCS code:_____/_____

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In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)

What is the recipient's health history? (Include chronic illness.)

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)

What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).)

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.) This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? ☐ Yes ☐ No
If yes, provide name and protocol number: _____

Is the requested product, service, or procedure considered to be safe? ☐ Yes ☐ No
If no, please explain. _____

Is the requested product, service or procedure effective? ☐ Yes ☐ No
If no, please explain. _____

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Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? ☐ Yes ☐ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available. _____

_____

_____

_____

What is the expected duration of treatment? _____

_____

_____

_____ _____

Requestor's Signature & Credentials **Date**

Fax this form to: 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593