

# 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**

**OptumRx**

**Fax: 1-844-403-1027**

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

**Standard Review Request**

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**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_