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

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.**		

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.**

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

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 Signature:	
	Date:

Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	**Billed through pharmacy ☐** **Buy and bill in office ☐**
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:	

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:	

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	
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

Additional information pertinent to this request: