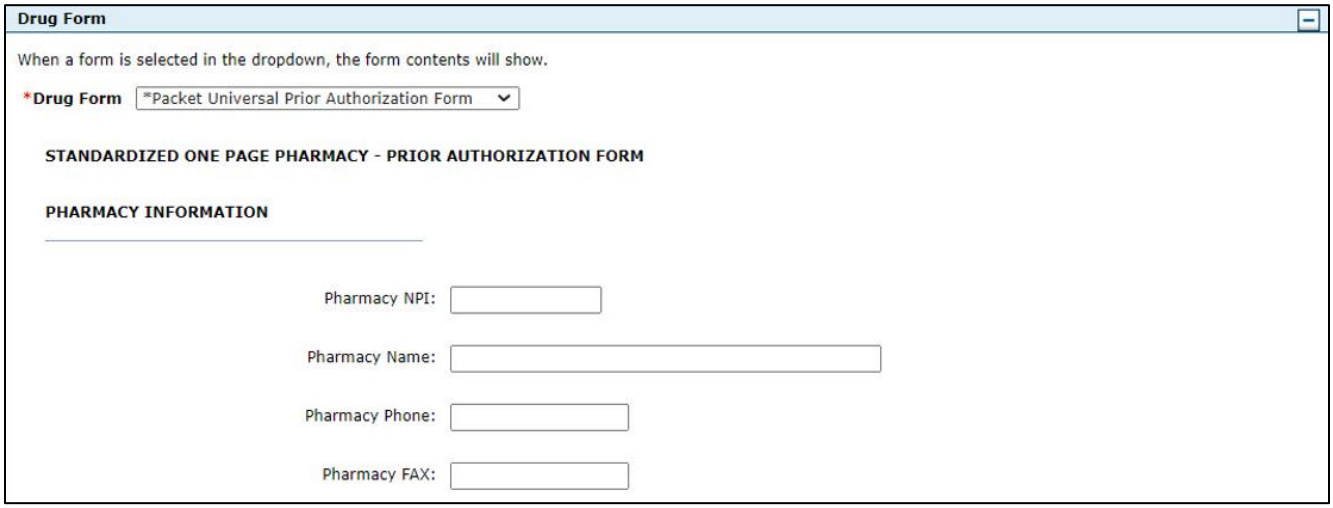
Job Aid

PRP-102 Universal PA Form Rules

The Universal PA Form is used in Healthcare Portal as part of the PA request in the Provider Portal. The Universal PA Form has been divided into several figures and tables describing the information that should be entered in the fields. For information on section Pharmacy Information, see Figure 1: Pharmacy Information Section.

Figure 1: Pharmacy Information Section



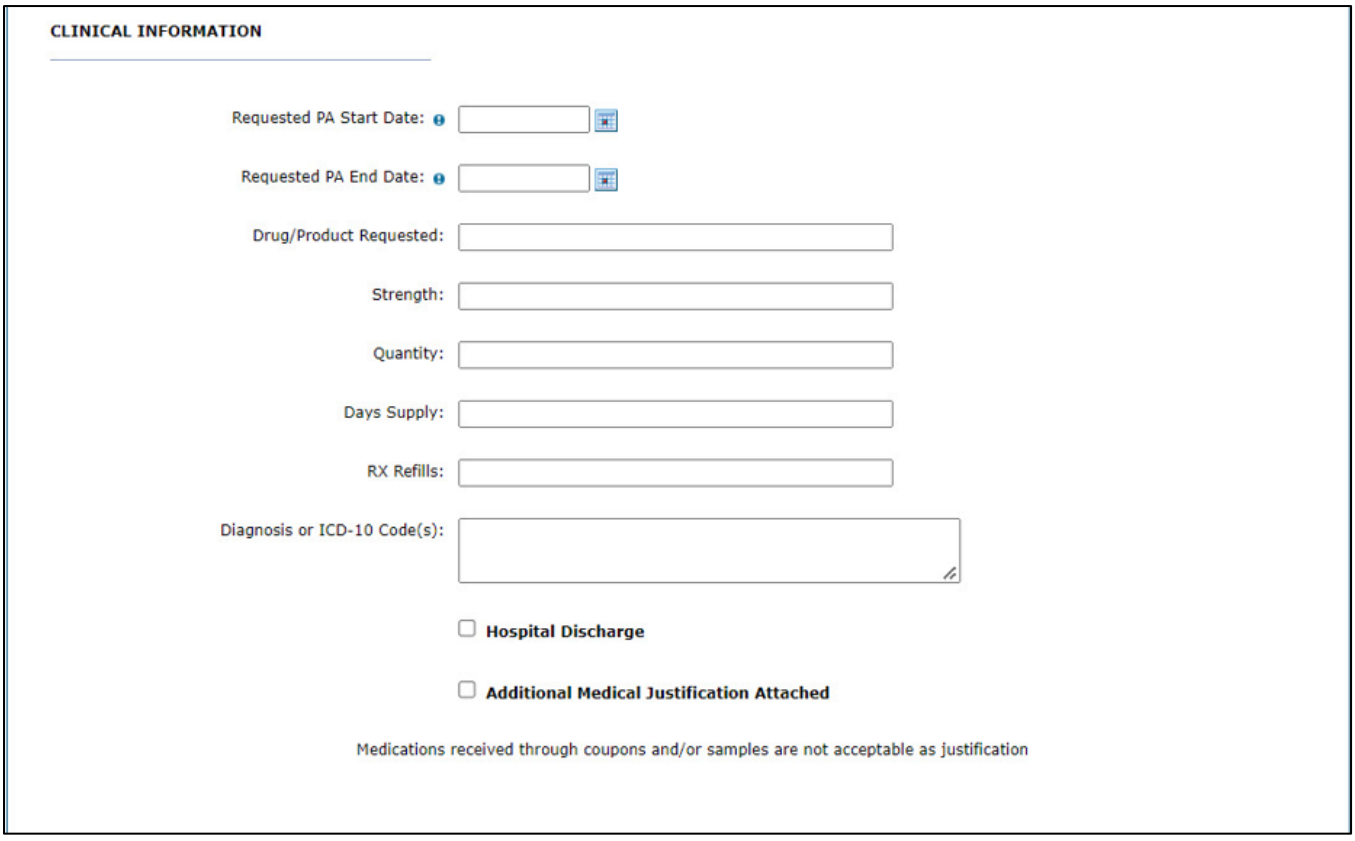
For information in the table, see Table 1: Pharmacy Information Fields.Table 1

Table 1: Pharmacy Information Fields

Field Name	Description	Format
Pharmacy NPI	NPI Identifier for the pharmacy on the PA request.	Character
Pharmacy Name	Name of pharmacy on the PA request	Character
Pharmacy Phone	Phone number for the pharmacy on the PA request.	Character
Pharmacy FAX:	FAX number for the pharmacy on the PA request.	Character

For information on section Clinical Information see, Figure 2: Clinical Information Section.

Figure 2: Clinical Information Section



For information in the table, see Table 2: Clinical Information Fields.

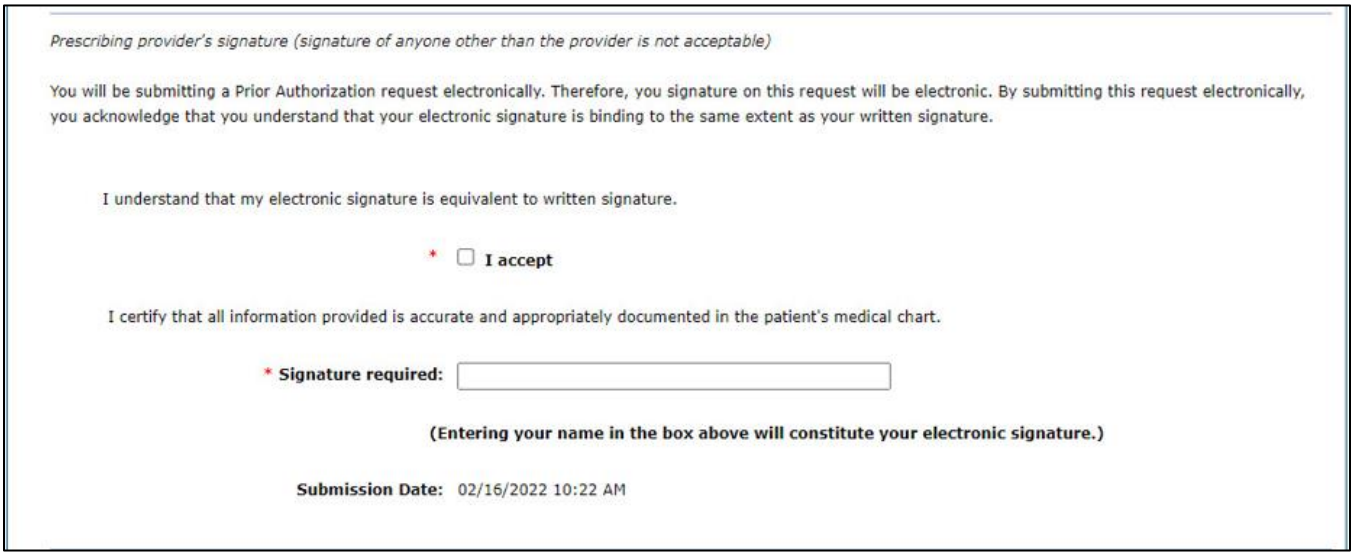
Table 2: Clinical Information Fields

Field Name	Description	Format
Requested PA Start Date	The start of the timeframe for which the service is requested to be performed/dispensed on the line item.	Date
Requested PA End Date	The end of the timeframe for which the service is requested to be performed/dispensed on the line item.	Date
Drug/Product Requested	Description of the drug that is being requested.	Character
Strength	Refers to the potency of the drug and is usually expressed in a metric quantity, such as 500 MG.	Character
Quantity	Quantity of the drug requested.	Character
Days' Supply	The number of days for which the drug should be prescribed.	Character
RX Refills	Number of refills requested.	Character
Diagnosis or ICD-10 Code(s)	Description or ICD-10 code representing the Member's diagnosis.	Character

Hospital Discharge	Checkbox indicating that this request is part of a hospital discharge.	Checkbox
Additional Medical Justification Attached	Checkbox indicating that documentation with additional medical justification has been attached to the PA request.	Checkbox

For information on section Signature, see: Figure 3: Signature Section.

Figure 3: Signature Section



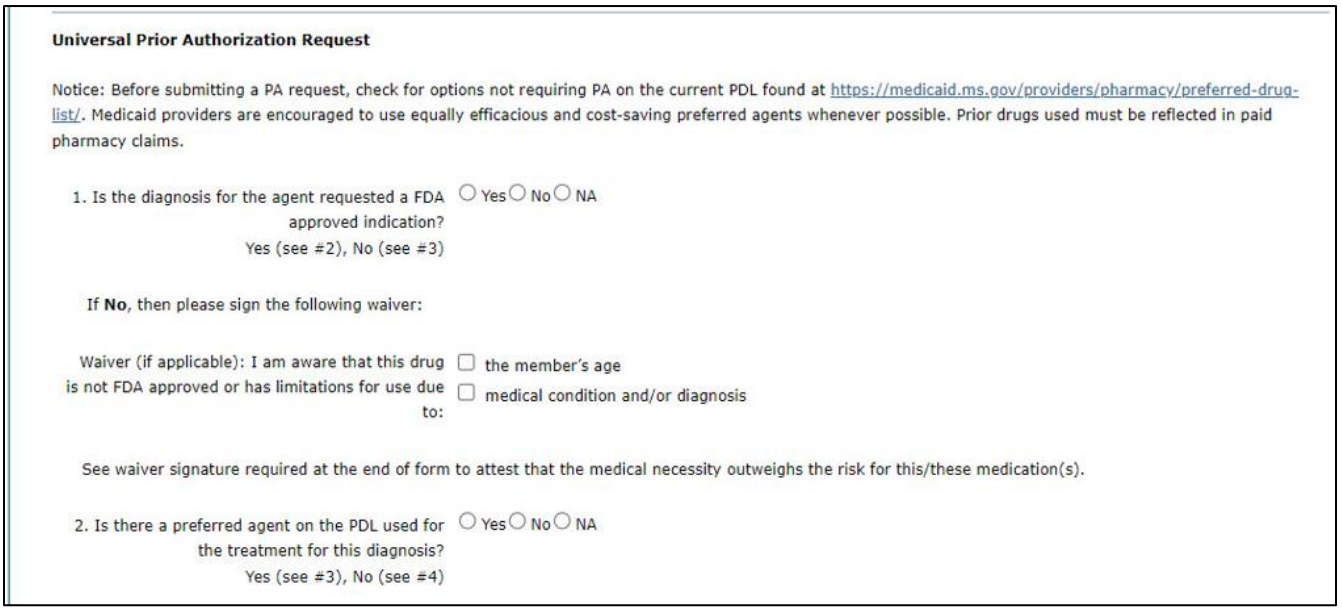
For information in the table, see Table 3: Signature Fields.

Table 3: Signature Fields

Field Name	Description	Format
I accept	Checkbox acknowledging the statement "I understand that my electronic signature is equivalent to written signature." Required field.	Checkbox
Signature required	Electronic signature required for submission of the PA request.	Character
Submission Date	Automatically populated	Date

For information on section Universal PA Request, see:Figure 4: Universal PA Request Questions 1 & 2.

Figure 4: Universal PA Request Questions 1 & 2



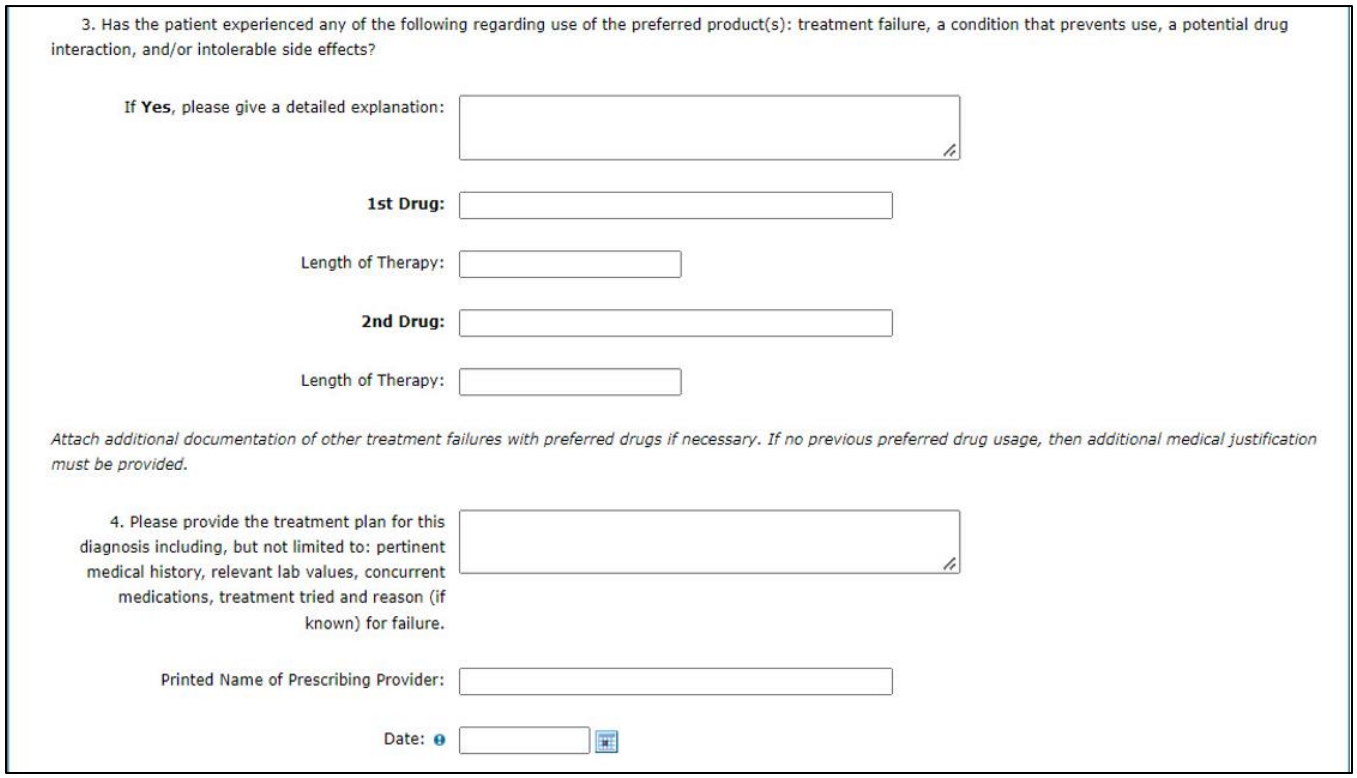
For information in the table, see Table 4: Universal PA Request Fields Questions 1 & 2.

Table 4: Universal PA Request Fields Questions 1 & 2

Field Name	Description	Format
1. Is the diagnosis FDA approved indication	Yes/No/NA selection to indicate if the diagnosis for the agent requested an FDA approved indication. Yes (see #2), No (see #3)	Radio button
1. Is the diagnosis (If No)	If the response to #1 No, sign waiver due to member's age, medical condition, or diagnosis.	Checkbox
2. Is there a preferred agent on the PDL	Yes/No/NA selection to indicate if there is a preferred agent on the PDL used for the treatment for this diagnosis. Yes (see #3), No (see #4).	radio button

1. For information on section Universal PA Request Questions 3 & 4, see: Figure 5: Universal PA Request Questions 3 & 4.

Figure 5: Universal PA Request Questions 3 & 4



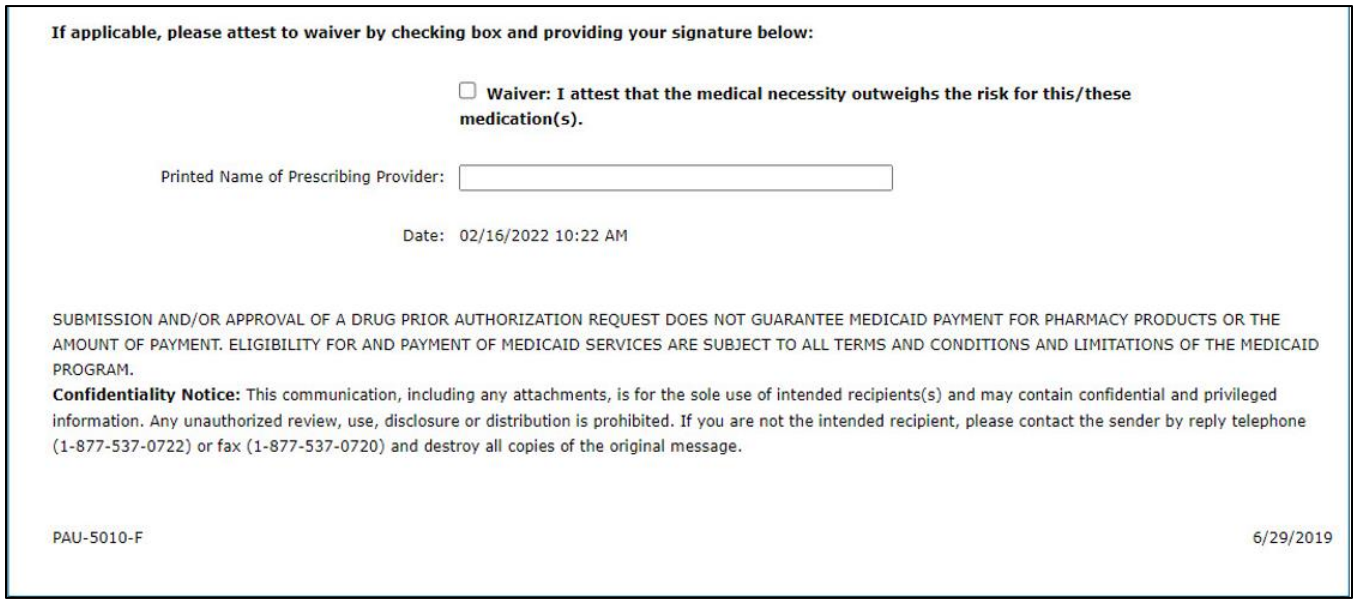
For information in the table, see Table 5: Universal PA Request Fields Questions 3 & 4.

Table 5: Universal PA Request Fields Questions 3 & 4

Field Name	Description	Format
3. Has patient experienced any of the following	Free form textbox to enter a detailed explanation if the patient has experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects	Character
1st Drug & 2nd Drug	Name of drug on the PA request.	Character
Length of Therapy (1st and 2nd Drug)	Length of therapy for the drug on the PA request.	Character
4. Please provide treatment plan	Free form textbox to provide treatment plan for the diagnosis including, but not limited to pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.	Character
Printed Name of Prescribing Provider	Printed name of the provider submitting the PA request.	Character
Date	Enter date in mm/dd/yyyy format.	Date

2. For information on section Waiver, see: Figure 6: Waiver Section.

Figure 6: Waiver Section



3. For information in the table, see For information on section Waiver, see: Figure 6: Waiver Section. Figure 6: Waiver Section.

Table 6: Waiver Fields

Field Name	Description	Format
Waiver	Attestation to waiver that medical necessity outweighs the risk for this/these medication(s).	Checkbox
Printed Name of Prescribing Provider	Printed name of the provider submitting the PA request.	Character
Date	System Date	Date