UniCare

Specialty Drug

Precertification-Clinical Worksheet

Review performed by Carelon Medical Benefits Management

Phone: 866-766-0247 / Fax: 888-223-0550

Initial request:_____ Subsequent request: _____ Start of service date:_____

Patient name:_____ DOB:_____ Member ID:_____

Provider:_____

Provider address:_____

Provider phone: _____ Provider fax:_____ Provider NPI #: _____

Requesting physician: _____

Physician address:_____

Physician phone: _____ Physician fax:_____ Physician NPI #: _____

Place of service: ___Home ___Outpatient hospital ___Dialysis center ___Office ___Ambulatory infusion center ___Ambulatory surgery center ___Other _____

DX (ICD-10):_____ Primary diagnosis: _____

Notification #: _____

In order to review the medical necessity for this service, we need the following information:

- Verification of type and frequency of service
- Documentation of medical necessity based on medical policies
- Prescription for required medications

PMH: _____

Where does the patient reside? ___Own home ___SNF ___ALF ___Other (specify): _____

Does the patient have a primary caregiver? ___No ___Yes (specify):_____

Social factors (family, community services): _____

Services requested (include J codes for medications):

Medication name and code for medication	Dosage	Route	Frequency	Start Date	Stop Date

Has this member been receiving this drug previously? ___No ___Yes (start date): _____

I attest the information provided is true and accurate to the best of my knowledge.

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____