UNIVERSITY OF COLORADO HEALTH PLAN
CU HEALTH PLAN "EXCLUSIVE" PRIOR AUTHORIZATION REQUEST FORM FOR
FACILITY-ADMINISTERED MEDICATIONS & INFUSIONS

REQUEST DATE:	**FIRST SERVICE DATE:** **URGENT* (EXPLAIN BELOW):** ☐ **ROUTINE:** ☐
PATIENT NAME:	**PROVIDER NAME:**
POLICY ID #: XRU	**CONTACT PHONE#**
DATE OF BIRTH:	**CONTACT FAX #**
UCHEALTH/CHCO MRN:	**OFFICE CONTACT NAME:**

MEDICATION(S) REQUESTED: NAME, J CODE, DOSE, FREQUENCY:

DIAGNOSIS: NAME(S) and ICD-10-CM CODE(S):

NUMBER OF DOSES/VISITS REQUESTED THROUGH 6/30/2027 (REQUIRED):

NAME OF FACILITY/SITE OF SERVICE:

FACILITY TAX ID/FACILITY NPI:

URGENCY REASON/OTHER INFO:

PLEASE READ:

***Urgent requests: 1-2 days before scheduled date of service. If otherwise, please explain above**

Processing times: ≤ 1 business day for urgent requests & ≤ 5 days for routine requests

Incomplete forms or requests lacking sufficient information may be returned for correction to limit unnecessary denials.

Approved by: **Date:**

Approval # :

Effective Dates/doses:

Denied by: **Date:**

Fax this form to (303) 493-7501 or email to:
MedManagement@CUMedicine.us