UnitedHealthcare Community Plan

ADHD Products - Arizona
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

ADHD Products - Arizona
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to a trial of at least three preferred products?** *(If yes, complete Section D above)*
MEMBERS LESS THAN 6 YEARS OF AGE	
□ Yes □ No	**Does the patient have a diagnosis of attention deficit hyperactivity disorder (ADHD)?**
□ Yes □ No	**Have psychosocial issues been evaluated before request for ADHD medications?**
□ Yes □ No	**Have non-medication alternatives been attempted before request for ADHD medications?** *If yes, list non-medication alternatives and dates:*
□ Yes □ No	**If the requested dose exceeds the Food and Drug Administration (FDA) maximum daily dose, is there clinical justification for exceeding the FDA maximum dose?** *If yes, document clinical justification:*

Provider Signature: _____ Date: _____