

Prior Authorization Request Form

A UnitedHealthcare Company

Please complete this <u>entire</u> 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.

Member Name:					rilours for reviev				
Member ID: Date Of Birth: Date Of Birth: Date Of Birth: Street Address: Office Phone: Street Address: Office Fax: City: State: ZIP Code: Office Street Address: City: State: ZIP Code: State: State: State: ZIP Code: State: State: State: State: ZIP Code: State: State: State: State: ZIP Code: State: Sta		ber In	format	tion		Prescrib	er Infor	mation	
Date Of Birth: Street Address:	Member Name:		Provider Name:						
Street Address: City: State: ZIP Code: Office Street Address: Phone: Allergies: City: State: ZIP Code: 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: Is this member pregnant? Yes No If yes, what is this member's due date? Is this member pregnant? Yes No If yes, what is this member's due date? Medication Information Strength: Quantity:	Member ID:				NPI #:		Specialty	r:	
City: State: ZIP Code: Office Street Address: Phone: Allergies: City: State: ZIP Code: 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: Is this member pregnant? Yes No If yes, what is this member's due date? Medication Information	Date Of Birth:		Office Phone:						
State: Allergies: City: State: ZIP Code:	Street Address:		Office Fax:						
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: \(\) Is this member pregnant? \(\) Yes \(\) No \(\) If yes, what is this member's due date? \(\) Medication: \(\) Medication: \(\) Strength: \(\) Directions for use: \(\) Quantity: \(\) Medication Administered: \(\) Self-Administered \(\) Physician's Office \(\) Other: \(\) Clinical Information What is the patient's diagnosis for the medication being requested? \(\) ICD-10 Code(s): \(\) Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives. \(\) What medication(s) does the patient have a history of failure to? (Please specify \(\) ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication) What medication(s) does the patient have a contraindication or intolerance to? (Please specify \(\) ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication) Are there any supporting laboratory or test results related to the patient's diagnosis? (Please specify or provide documentation) Additional information that may be important for this review	City:	State:		ZIP Code:	Office Street Addre	ess:			
Is this patient currently hospitalized?	Phone:	Allergies:		:	City:	State	:	ZIP Code:	
Medication: Directions for use: Medication Administered: Self-Administered Physician's Office Other: Clinical Information What is the patient's diagnosis for the medication being requested? ICD-10 Code(s): Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives. What medication(s) does the patient have a history of failure to? (Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication) What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication) Are there any supporting laboratory or test results related to the patient's diagnosis? (Please specify or provide documentation) Additional information that may be important for this review	Is this patient current	y hospi	italized	? □ Yes □ No If re lo If yes, what is th	cently discharged nis member's due	, list disch	arge date		
Directions for use: Medication Administered: Self-Administered Physician's Office Other:				Medicatio	n Information				
Medication Administered: Self-Administered Physician's Office Other: Clinical Information What is the patient's diagnosis for the medication being requested? ICD-10 Code(s): Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives What medication(s) does the patient have a history of failure to? (Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication) What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication) Are there any supporting laboratory or test results related to the patient's diagnosis? (Please specify or provide documentation) Additional information that may be important for this review	Medication:				Strength:				
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Provider Signature: Date:	Are there any supporting	n to or sp	oecific iss	sues resulting in intolera	ance to each medicati	ion) s? (Please s	specify or p		
	Provider Signature:					Da	te:		

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