

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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://www.uhcprovider.com) for a list of preferred alternatives

<b>Member First name:</b>		<b>Member Last name:</b>		<b>Member DOB:</b>	
<b>Clinical and Drug Specific Information</b>					
<b>ALL REQUESTS</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Is the patient already established on ICS/LABA combination therapy (e.g. Advair, Symbicort, Dulera)?</b> <i>(If yes, complete Section D above)</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Does the patient have a history of failure, contraindication, or intolerance to treatment with at least a 30-day trial of any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Beclomethasone dipropionate (Qvar) <input type="checkbox"/> Budesonide (Pulmicort) <input type="checkbox"/> Fluticasone propionate (Flovent HFA) <input type="checkbox"/> Mometasone (Asmanex Twisthaler)			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Does the patient have a history of failure, contraindication, or intolerance to treatment with at least a 30 day trial of any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> A long-acting beta-agonist (e.g. Foradil, Serevent, Striverdi, Arcapta) <input type="checkbox"/> An orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent, Tudorza, Incruse Ellipta) <input type="checkbox"/> An orally inhaled anticholinergic agent/long-acting beta-agonist combination agent (e.g. Anoro Ellipta, Stiolto Respimat)			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Does the patient have a history of failure, contraindication, or intolerance to treatment with any of the following preferred products?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Advair HFA (fluticasone/salmeterol) <input type="checkbox"/> Dulera (mometasone/formoterol) <input type="checkbox"/> Symbicort (budesonide/formoterol)			

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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