UnitedHealthcare®

Medical Drugs Prior Authorization Form

You may use this form to request prior authorization for medical drugs. Thank you. Alternatively, you may submit your request online using our Prior Authorization and Notification tool on Link. You can access the tool at UHCprovider.com/paan. You may also initiate your request by phone by calling the number on the back of the member's health care ID card.

Date: _____

Patient Information		
Member Name:	**Member identification (ID) Number:**	
Subscribe Number:	**Member Address:**	
Member Date of Birth:	**Member Phone:**	
Authorized Representative:	**Authorized Representative Phone:**	
Primary Insurance Name with ID Number:		
Gender:	**Height/Weight:**	**Allergies:**

Requesting Provider Information	
Provider Name:	**Provider NPI Number:**
Provider Address:	
Provider Phone:	**Provider Tax ID Number:**
Provider Fax:	**Provider DEA (if required):**
Office Contact Person:	**Provider Specialty:**
Office Contact Fax:	**Office Contact Phone:**

A list of medications which require prior authorization or step therapy is available at https:// www.uhcprovider.com/en/prior-auth-advance-notification/prior-auth-specialty-drugs.html

Drug Information	
Medication Name and Strength:	
Directions for Use:	
New Therapy/Renewal:	**Duration:**
Quantity:	**HCPCS/CPT® Codes:**

Administration Location (Check below):		**Administration Method (Check below):**	
Physician's Office	☐	Oral	☐
Infusion Center	☐	Topical	☐
Patient Home	☐	Injection	☐
Home Health Care	☐	IV	☐
Outpatient Hospital	☐	Other:	☐
Facilities: Long Term Care, Skilled Nursing or Acute Rehabilitation	☐		
Other Location (Please Specify):_____	☐		

Diagnosis for Medication:	**ICD-9/ Codes:**
Relevant Medications tried and failed:	

Servicing Provider Information (If different than Requesting Provider Information)	
Provider Name:	**Provider Tax ID Number:**
Provider Address:	
Provider Fax Number:	**Provider Phone Number:**

Please attach relevant clinical information to this request.

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber or Authorized Signature: _____**Date**: _____

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