

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>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD) <input type="checkbox"/> Binge eating disorder (BED) <input type="checkbox"/> Fatigue associated with medical illness in palliative or end of life care <input type="checkbox"/> Fatigue associated with multiple sclerosis <input type="checkbox"/> Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome) <input type="checkbox"/> Narcolepsy
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?</b>
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives for the given diagnosis?</b> <i>(If yes, complete Section D above)</i>
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**LESS THAN THE FDA APPROVED MINIMUM AGE**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient unresponsive to, or has had an inadequate response to behavioral therapy?</b> <i>(If yes, complete Section D above)</i>
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient experiencing moderate-severe continuing disturbance in function despite behavioral therapy?</b>
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**MULTI-SOURCE BRAND MEDICATION REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient meet any of the following circumstances?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> The multi-source brand is being requested because of an adverse reaction, allergy or sensitivity to a generic equivalent <input type="checkbox"/> The multi-source brand is being requested due to a therapeutic failure with the generic equivalent <input type="checkbox"/> The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient <input type="checkbox"/> Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient
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**KAPVAY / CLONIDINE ER**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Guanfacine ER (generic Intuniv) <input type="checkbox"/> Atomoxetine (generic Strattera)
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**VYVANSE (NEW & CONTINUATION REQUESTS)**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to any of the following?</b> <i>(If yes, check all that apply and complete Section D above)</i> <input type="checkbox"/> BRAND Adderall XR (amphetamine/dextroamphetamine salts extended-release) <input type="checkbox"/> Methylphenidate extended-release tablet or capsule (generic Concerta or Metadate CD)
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of or potential for a substance abuse disorder?</b>
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to atomoxetine (Strattera)?</b>
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**CONTINUATION OF THERAPY - VYVANSE**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there rationale for needing to continue the patient on Vyvanse therapy?</b> <i>If yes, please provide rationale:</i>
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of positive clinical response to Vyvanse therapy?</b>
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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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