

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 for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient meet any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Patient is receiving cancer chemotherapy <input type="checkbox"/> Diagnosis of anorexia with weight loss in a patient with AIDS
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unable to swallow capsules?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to formulary generic dronabinol? <i>(If yes, complete section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to a 5HT-3 receptor antagonist? e.g. Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron) <i>(If yes, complete section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete section D above)</i> <input type="checkbox"/> Ativan (lorazepam) <input type="checkbox"/> Compazine (prochlorperazine) <input type="checkbox"/> Decadron (dexamethasone) <input type="checkbox"/> Haldol (haloperidol) <input type="checkbox"/> Phenergan (promethazine) <input type="checkbox"/> Reglan (metoclopramide) <input type="checkbox"/> Zyprexa (olanzapine)
ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient on antiretroviral therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to Megace (megestrol)? <i>(If yes, complete section D above)</i>

Provider Signature: _____ **Date:** _____

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