UnitedHealthcare Community Plan

Chantix

Prior Authorization Request Form

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: □ New or □ Continuation of Therapy? If continuation, list start date: _______________

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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 www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Is the treatment being requested for tobacco cessation?**
□ Yes □ No	**Has the patient received any form of tobacco cessation information or counseling?** □ Prescriber provided advice/information on importance of tobacco cessation □ Telephonic support □ In person counseling either through a support group or one on one with prescriber or prescribers representative or pharmacist counseling □ Other: ____________
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to one of the following:** *(If yes, check which applies and complete Section D above)* □ Nicotine replacement patches OTC (e.g. Nicoderm CQ-OTC) □ Nicotine gum OTC (e.g. Nicorette gum- OTC) □ Nicotine lozenge OTC (e.g. Nicorette lozenge-OTC)
□ Yes □ No	**Is the patient currently taking nicotine replacement therapy** (or if currently being used will be discontinued prior to start of Chantix)**?** *List therapy*:
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to bupropion?** *(If yes, complete Section D above)*
□ Yes □ No	**Is the patient currently taking bupropion for tobacco cessation** (or if currently be used will be discontinued prior to the start of Chantix)**?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Does the patient continue to receive tobacco cessation counseling?**
□ Yes □ No	**Has the patient already received 180 days of therapy in the last 12 months?** *If yes, List start date:*

Provider Signature: ________________________________ **Date:** ______________

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