UnitedHealthcare Community Plan

Antipsychotics - Virginia
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:
NPI #:	Phone:	Fax:	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 the patient's PDL at 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**	**Does the patient have any of the following diagnoses:** *(check which applies)* □ Schizophrenia or schizoaffective disorder □ Bipolar disorder □ Autism □ Major depressive disorder □ Tourette's
CHILDREN LESS THAN 18 YEARS OF AGE	
□ **Yes** □ **No**	**Is the prescribing provider a psychiatrist, neurologist, or developmental/behavioral pediatrician?**
□ **Yes** □ **No**	**If "No" to the previous question, has the provider consulted one before prescribing the requested medications?**
□ **Yes** □ **No**	**Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target, and treatment plans clearly identified and documented?**
□ **Yes** □ **No**	**Is a psychiatric assessment scheduled, or are services not available in the area?** *(check which applies)* □ **Psychiatric assessment is scheduled –** *start date:* _____ □ **Services are not available in the area** □ ***Other reason:***
□ **Yes** □ **No**	**Is psychosocial treatment in place without adequate clinical response, and psychosocial treatment with parental involvement will continue for the duration of therapy?**
□ **Yes** □ **No**	**Has informed consent for this medication been obtained from the parent or guardian?**
□ **Yes** □ **No**	**Has a family assessment been performed (including parental psychopathology and treatment needs), and have family functioning and parent-child relationship been evaluated?**
NON-PREFERRED MEDICATIONS	
□ **Yes** □ **No**	**Has the patient demonstrated failure or intolerance to any of the preferred formulary/PDL alternatives for the given diagnosis?** *(If yes, complete Section D above)* *If no, list reason:*
EXCEEDING QUANTITY LIMIT	
□ **Yes** □ **No**	**Is there a reason why a greater quantity of medication is required to treat the patient's condition?** *If yes, list reason:*

Provider Signature: _____ **Date:** _____