UnitedHealthcare Community Plan

Antidiabetics, Amlyin Analogs - Washington
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 the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check which applies)

- ☐ Type 1 diabetes mellitus
- ☐ Type 2 diabetes mellitus
- ☐ Other, **List diagnosis**: _____

- Did the patient fail to achieve desired glycemic control despite optimal insulin therapy? □ Yes □ No

- Is the patient currently receiving optimal mealtime insulin or continuous insulin infusion (insulin pump)?
□ Yes □ No

- Does the patient have any of the following: □ Yes □ No (check which applies)

- □ Diagnosis of gastroparesis or requiring medication to stimulate gastrointestinal motility (i.e. metoclopramide or erythromycin)
- □ Hypoglycemia unawareness (e.g., inability to detect and act upon the signs or symptoms of hypoglycemia)
- □ Poor compliance with current insulin regimen
- □ Poor compliance with self-blood glucose monitoring
- □ HbA1C (hemoglobin A1c) level greater than (>) 9% within the last 3 months
- □ Recurrent severe hypoglycemia that required assistance during the past 6 months

Requests for CONTINUATION OF THERAPY:

- Is there documentation of positive clinical benefit? □ Yes □ No

Provider Signature: _____ Date: _____