

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	<p>Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?</p> <p><i>If yes, Start Date: _____ Discharge Date: _____</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient been receiving treatment with the requested non-preferred agent and is new to the plan (enrollment date within the past 90 days)?</p> <p><i>If yes, List Start Date: _____</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>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)</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do both of the following apply to the patient: (Check which applies)</p> <p><input type="checkbox"/> Trial of two preferred products, other than the generic equivalent to the requested brand</p> <p><input type="checkbox"/> Trial of the generic equivalent of the product being requested from 5 manufacturers. (If fewer than 5 manufacturers, must try all manufacturers)</p>

REQUESTS TO EXCEED QUANTITY LIMIT

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there a reason why a greater quantity of medication is required to treat the patient's condition?</p> <p><i>If yes, list reasoning: _____</i></p>
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THERAPEUTIC DUPLICATION FOR MEMBERS UNDER THE FDA APPROVED AGE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient transitioning from one antipsychotic to another or will the patient remain on both medications?</p> <p><input type="checkbox"/> Transitioning from one antipsychotic to another <i>List drug that will be stopped and date it will be stopped: _____</i></p> <p><input type="checkbox"/> No, patient will remain on both medications</p>
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MENTAL HEALTH POLYPHARMACY

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will the patient remain on five or more psychotropic/mental health medications or is the patient titrating/changing medications and will be on less than five psychotropic/mental health medications? (If yes, check which applies)</p> <p><input type="checkbox"/> Transitioning medications AND will be on LESS THAN five psychotropic medications. <i>Please list drugs that will be stopped and date of discontinuation: _____</i></p> <p><input type="checkbox"/> Patient will remain on five or more psychotropic medications</p>
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CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of positive clinical response to treatment?</p> <p><i>If yes, list response: _____</i></p>
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Provider Signature: _____ **Date:** _____

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