

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](http://www.uhcprovider.com) for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
--------------------	-------------------	-------------

**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of type 2 diabetes mellitus?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, intolerance, or contraindication to metformin at a minimum dose of 1500mg daily for 90 days?</b> <i>(If yes, complete section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, intolerance, or contraindication to <u>three</u> of the following?</b> <i>(If yes, check which applies and complete section D above)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tradjenta</li> <li><input type="checkbox"/> Januvia</li> <li><input type="checkbox"/> Onglyza</li> <li><input type="checkbox"/> Kombiglyze XR</li> <li><input type="checkbox"/> Janumet</li> <li><input type="checkbox"/> Janumet XR</li> <li><input type="checkbox"/> Jentadueto</li> </ul>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.