UnitedHealthcare Community Plan

Diabetes- Non Insulin Agents - Ohio
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 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**	**Is there an inadequate clinical response to metformin products (either single-ingredient or in a sulfonylurea/metformin or TZD/metformin combination) including a trial of no less than three months of at least one preferred metformin product?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there a reason the patient cannot be changed to a metformin product such as:** *(If yes, check which applies)* □ Allergy to metformin □ Contraindication or drug interaction to metformin □ History of unacceptable/toxic side effects to metformin
	SOLIQUA, XULTOPHY
□ **Yes** □ **No**	**Is there an inadequate clinical response to a trial with a preferred GLP 1 receptor agonist AND a preferred long acting insulin?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there a reason the patient cannot be changed to a preferred GLP 1 receptor agonist AND a preferred long acting insulin such as:** *(If yes, check which applies)* □ Allergy to all preferred GLP 1 receptor agonists and all preferred long acting insulins □ Contraindication to all preferred GLP 1 receptor agonists and all preferred long acting insulins □ History of unacceptable/toxic side effects to all preferred GLP 1 receptor agonists and all preferred long acting insulins
	SYMLIN
□ **Yes** □ **No**	**Is there an inadequate clinical response to a trial of no less than three months to any preferred insulin product?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there a reason the patient cannot be changed to a preferred insulin product such as:** *(If yes, check which applies)* □ Allergy to preferred insulins □ Contraindication or drug interaction to preferred insulins □ History of unacceptable/toxic side effects to preferred insulins
	QTERN, STEGLUJAN
□ **Yes** □ **No**	**Is there an inadequate clinical response to no less than a three month trial with any preferred DPP-4 product and any preferred SGLT2 product?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there a reason the patient cannot be changed to a preferred DPP-4 product AND a preferred SGLT2 product such as:** *(If yes, check which applies)* □ Allergy to all preferred DPP-4 products AND all preferred SGLT2 products □ Contraindication to all preferred DPP-4 products AND all preferred SGLT2 products □ History of unacceptable/toxic side effects to all preferred DPP-4 products AND all preferred SGLT2 products
	NON-PREFERRED MEDICATIONS
□ **Yes** □ **No**	**Is there a reason the patient cannot be changed to a medication within the same class not requiring prior approval such as:** *(If yes, check which applies)* □ Allergy to medications not requiring prior approval □ Contraindication or drug interaction to medications not requiring prior approval □ History of unacceptable/toxic side effects to medications not requiring prior approval

Provider Signature: _____ **Date:** _____