

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	Does the patient have a diagnosis of type 2 diabetes mellitus?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, intolerance, or contraindication to at least <u>two</u> generic agents, one of which must be metformin at a minimum dose of 1500 mg daily for 90 days? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure for 90 days, intolerance, or contraindication to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Adlyxin <input type="checkbox"/> Trulicity <input type="checkbox"/> Victoza 1.2mg per day (2 Pen Pack)

VICTOZA 1.8MG PER DAY (3 PEN PACK)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure to achieve acceptable glycemic control with Victoza 1.2mg per day for 90 days (2 Pen Pack)?
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RYBELSUS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unable to self-inject due to any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure <input type="checkbox"/> Lipohypertrophy <input type="checkbox"/> Physical impairment <input type="checkbox"/> Visual impairment
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, intolerance, or contraindication to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Steglatro <input type="checkbox"/> Segluromet

Provider Signature: _____ **Date:** _____

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