

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:
---------------------------	--------------------------	--------------------

Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient already established on ICS/LABA combination therapy (e.g. Advair, Symbicort, Dulera)? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to treatment with at least a 30-day trial of any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Beclomethasone dipropionate (Qvar) <input type="checkbox"/> Budesonide (Pulmicort) <input type="checkbox"/> Fluticasone propionate (Flovent HFA) <input type="checkbox"/> Mometasone (Asmanex Twisthaler)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to treatment with at least a 30 day trial of any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> A long-acting beta-agonist (e.g. Foradil, Serevent, Striverdi, Arcapta) <input type="checkbox"/> An orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent, Tudorza, Incruse Ellipta) <input type="checkbox"/> An orally inhaled anticholinergic agent/long-acting beta-agonist combination agent (e.g. Anoro Ellipta, Stiolto Respimat)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to treatment with any of the following preferred products? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Advair HFA (fluticasone/salmeterol) <input type="checkbox"/> Dulera (mometasone/formoterol) <input type="checkbox"/> Symbicort (budesonide/formoterol)

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.