

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 a diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication or intolerance to Spiriva Handihaler (tiotropium)? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Spiriva Handihaler) to control his/her COPD due to one of the following: <input type="checkbox"/> Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (document impairment) <input type="checkbox"/> Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is <60 L/min) <i>If yes, check which applies and list rationale:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication or intolerance to ipratropium nebulized solution (generic Atrovent)? <i>(If yes, complete Section D above)</i>
CONTINUATION OF THERAPY	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented positive clinical response to therapy? <i>If yes, list response:</i>

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.