UnitedHealthcare Community Plan

Onglyza / Kombiglyze XR / Tradjenta / Jentadueto

URGENT-24 HOUR

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C – MEDICATION INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD 10 Code:**

Does the patient have a diagnosis of type 2 diabetes mellitus? ☐YES ☐ NO

Has the patient tried and failed any of the following? (check any that apply)

- ☐ Metformin/metformin ER (eg, Glucophage, Glucophage XR)
- ☐ Sulfonylurea [eg, Amaryl (glimepiride), Diabeta (glyburide), Glucotrol (glipizide)]
- ☐ Thiazolidinedione (TZD) [eg, Actos (pioglitazone), Avandia (rosiglitazone)]
- ☐ Insulin [eg, Humalog, Humulin, Novolin, Novolog, Lantus]
- ☐ Byetta (exenatide)

For any that are checked please provide dates of therapy and reason for discontinuation:

_____

_____

_____

Physician Signature: _____ Date: _____