

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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:		Specialty:
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:		Allergies:	City:	State:	ZIP Code:
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: _____ Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____					
Medication Information					
Medication:				Strength:	
Directions for use:				Quantity:	
Medication Administered: <input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____					
Clinical Information					
What is the patient's diagnosis for the medication being requested? _____ _____					
ICD-10 Code(s): _____					
Are there any supporting laboratory or test results related to the patient's diagnosis? <i>(Please specify or provide documentation)</i>					
Previous Medication Trials / Contraindications					
<u>Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives</u>					
What medication(s) does the patient have a history of <u>failure</u> to? <i>(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)</i>					
What medication(s) does the patient have a <u>contraindication or intolerance</u> to? <i>(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)</i>					
Additional information that may be important for this review					

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 history of therapeutic failure, contraindication, or intolerance of the preferred statin lipotropics? <i>(If yes, complete "Previous Medication Trials/Contraindications" section on first page)</i>		
THERAPEUTIC DUPLICATION			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being titrated to, or tapered from, a drug in the same class?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested?		

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.