UnitedHealthcare Community Plan

Insulins
Prior Authorization Request Form

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: ☐ **New or** ☐ **Continuation of Therapy? If continuation, list start date:** _______________

Is this patient currently hospitalized? ☐ **Yes** ☐ **No If recently discharged, list discharge date:** ________________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	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? ☐ **Yes** ☐ **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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
REQUESTS FOR PEN PRODUCTS	
☐ Yes ☐ No	**Does the patient have a visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin?**
☐ Yes ☐ No	**Does the patient have a physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin?** *If yes, list disability/handicap:*
☐ Yes ☐ No	**Is the patient unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c?** *If yes, list HbA1c and date:*
ADMELOG SOLOSTAR	
☐ Yes ☐ No	**Does the patient have a history of failure to Admelog vial as demonstrated by poorly controlled diabetes based on hemoglobin A1C?** *(If yes, complete Section D above)* *If yes, list HbA1c and date:*
RAPID-ACTING INSULIN (NOVOLOG, HUMALOG, FIASP, OR APIDRA)	
☐ Yes ☐ No	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* ☐ Admelog Vial ☐ Admelog Solostar Pen
HUMULIN R U-500 VIAL/PEN PRODUCTS	
☐ Yes ☐ No	**Does the patient require more than 200 units of insulin per day?**
☐ Yes ☐ No	**If requesting Humulin R U-500 PEN, does the patient have a history of failure, contraindication, or intolerance to Humulin R U-500 vial?** *(If yes, complete Section D above)*
INTERMEDIATE-ACTING PEN (HUMULIN N KWIKPEN)	
☐ Yes ☐ No	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* ☐ Humulin N U-100 vial ☐ Novolin N U-100 vial
INSULIN MIX PEN	
☐ Yes ☐ No	**Does the patient have a history of failure, contraindication, or intolerance to the corresponding preferred insulin mix vial?** *(If yes, complete Section D above)*
LONG ACTING INSULIN PEN/VIAL PRODUCTS	
☐ Yes ☐ No	**Does the patient have a history of failure, intolerance, or contraindication to Basaglar KwikPen?** *(If yes, complete Section D above)*
QUANTITY LIMIT	
☐ Yes ☐ No	**Does the provider confirm that the patient requires a greater quantity due to poorly controlled diabetes based on blood glucose and/or hemoglobin A1c?** *If yes, list blood glucose and/or HbA1c and date:*

Provider Signature: ____ **Date:** ____________________

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