UnitedHealthcare Community Plan

# Lonhala Magnair and Yupelri
## 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: |
| 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? □ 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 at www.uhcprovider.com for a list of preferred alternatives**

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# Lonhala Magnair and Yupelri
## Prior Authorization Request Form

| Member First name: | Member Last name: | Member DOB: |
|---|---|---|
| | | |

## Clinical and Drug Specific Information

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

**Provider Signature: _____ Date: _____**