

Insulin Pen Needles and Syringes - Washington Prior Authorization Request Form

Please complete this <u>entire</u> 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 Inforr	nation							
First Name:	Last Name:				Member ID:			
Address:								
City:	State:			ZIP C	ZIP Code:			
Phone:	DOB:			Allergi	Allergies:			
Primary Insurance Information	(if any):				I			
Is the requested medicati	on: □ New or □	Continuat	ion of Thera	apy? If continuation,	list sta	rt date:		
Is this patient currently h	ospitalized?	Yes □ No	If recently	discharged, list disc	charge	date:		
Section B - Provider Infor	mation							
First Name:				Last Name:			M.D./D.O.	
Address:	Address:			City:			ZIP code:	
Phone:	Fax:		NPI#:			Specialty:		
Office Contact Name / Fax atte	ention to:				•			
Section C - Medical Inform	nation							
Medication:						Strength:		
Directions for use:						Quantity:		
Diagnosis (Please be specific & provide as much information as possible):							ICD-10 CODE:	
Diagnosis (Flease be specific	ox provide as muc	ii iiiloiiilatioi	i as possible)	•		100-100	ODE.	
Is this member pregnant?	Yes □ No	If yes,	what is this	member's due date? _				
Section D - Previous Med	ication Trials							
Medication Name	Strength	Dire	ctions	Dates of Therap	ру	Reason for failure / discontinuation		
						4.00	<u> </u>	
Section E – Additional info	ormation and Ex	xplanation (of why pref	erred medications w	ould no	t meet th	ne patient's needs:	
				ider.com for a list of				



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Member First name:		Member Last name:	Member DOB:			
		Clinical and Drug Specific Inform	ation			
		ALL REQUESTS				
□ Yes □ No	Does the patient have history of failure to the preferred BD insulin pen needle or syringe? (If yes, complete Section D above)					
□ Yes □ No	Is there documentation a If yes, list rationale:	as to why the patient is unable to use th	e preferred BD product?			
QUANTITY LIMITS						
[NOTE: The quantity limit for both pen needles and syringes is 6 of each per day]						
□ Yes □ No	Is there physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin?					
Provider Sig	gnature:		Date:			

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