

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: <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: _____		

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check which applies)

- | | |
|---|---|
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Endometrial hyperplasia or prevention of endometrial hyperplasia |
| <input type="checkbox"/> Abnormal uterine or vaginal bleeding | <input type="checkbox"/> Prevention of preterm delivery of current pregnancy |
| <input type="checkbox"/> History of preterm birth | <input type="checkbox"/> Other. List diagnosis: _____ |

**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**

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.