UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

24 Hour Urgent

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD 10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: DAW (Initial here):

Physician Signature**: By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication**.**

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐Yes ☐No

Is this medication a **New Start**? ☐Yes ☐No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self Administered ☐ LTC ☐ Physician's Office ☐

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Medical Exception Worksheet/Prescription Order Form
Specialty Pharmacy (ORAL / INJECTABLE) Medication
Please complete and return fax to 866-940-7328

PATIENT DEMOGRAPHICS / INSURANCE INFORMATION **24 Hour Urgent**

Patient Name: _____ Unison ID #:

Insured's Name: _____ Insured's SSN/Group #:

Primary Insurance Information: ID #: _____ Group #:

Secondary Insurance Information: ID#: _____ Group #:

Patient Mailing Address: _____ DOB:

Patient Phone day: (_____) _____ Evening: (_____) _____

Best time to Contact: _____ Sex: O M O F Primary language: _____

PRESCRIPTION (Required)

Drug/Strength/Dose: _____ O Coordinating administration supplies Sig: _____
(As required by PA law, generics will be dispensed if available)

MD Name: _____ MD Signature **(required)**:

DEA #: _____ MD License #: _____ NPI # (Required):

Physician Address: _____ City, State Zip: _____

Physician Phone #: (_____) _____ Physician Fax #: (_____) _____

For injectable medications only:

Medication to be Administered: O Physician's Office **(In Office / Outpt Facility)** O Patient's Home **(Administered)**

Deliver Rx to: O Physician's Office O Patient's Home O Other Address: _____

Contact Person/Ext.: _____ Date Needed: _____ QTY: _____ Duration: _____

CLINICAL INFORMATION

Clinical Diagnosis: _____ ICD-10 Code: _____

Pregnancy Status: O YES O NO If yes, Expected Due Date: _____

Please include details of past relevant medical treatment, which substantiates need for exception to using formulary alternatives: (i.e. past prescription treatment failures, documented side effects, lab values, etc.)

Formulary Medication Attempted	Dose	Dates of Therapy	Reason for Discontinuing Therapy

Height: _____ Weight: _____ Allergies (including food): _____

Current Patient Medication Profile including OTCs & herbals: (drug / dose / directions)

_____

Additional Information: _____

Physician Signature**: By signing above the physician is providing Prescription Solutions with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication. The Physician Signature** above is not required if the physician will supply the medication directly to the patient, if the patient has already been provided with a written prescription or if the physician will provide the prescription to a pharmacy via phone or fax.