

**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:	Policy #:	Group #:

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 - Physician Information**

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:

**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**

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Clinical and Drug Specific Information**

- Does the patient have a history of any of the following anti-anginal treatments: ?  Yes  No (check which applies)  
 One beta-blocker  
 One calcium channel blocker  
 One long-acting nitrate therapy  
 (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

**Section F – Additional information and Explanation of why preferred medications would not meet the patient's needs**  
*Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for a list of preferred alternatives*

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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