

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 |
|-----------------|----------|------------|------------------|--------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**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**

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

Clinical and Drug Specific Information

ALL REQUESTS

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Clostridium difficile-associated diarrhea (CDAD) <input type="checkbox"/> Enterocolitis due to Staphylococcal aureus |
|--|---|

CLOSTRIDIUM DIFFICILE-ASSOCIATED DIARRHEA (CDAD): CONTINUATION OF THERAPY

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have recurrence of <i>Clostridium difficile</i> infection after prior treatment with oral vancomycin? <i>If yes, list dates of therapy:</i> |
|--|--|

Provider Signature: _____ **Date:** _____

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