

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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:
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: _____ Is this member pregnant? ☐ Yes ☐ No If yes, what is this member's due date? _____					
Medication Information					
Medication:				Strength:	
Directions for use:				Quantity:	
Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____					
Clinical Information					
What is the patient's diagnosis for the medication being requested? _____					
ICD-10 Code(s): _____					
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives					
What medication(s) does the patient have a history of failure to? (Please specify <u>ALL</u> medication(s)/strengths tried, directions, specific dates of therapy, length of trial, reason for discontinuation of each medication, and include chart notes to support the use of any preferred alternatives)					
What medication(s) does the patient have a contraindication or intolerance to? (Please specify <u>ALL</u> medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)					
Are there any supporting laboratory or test results related to the patient's diagnosis? (Please specify or provide documentation)					
Additional information that may be important for this review					

Provider Signature: _____ **Date:** _____

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