Global non-preferred prior authorization request form

UnitedHealthcare Community Plan of Texas

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:	Date of birth (DOB):	Allergies:
Primary insurance information (if any):		

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: Provider information

First name:	Last name:	☐ M.D.: ☐ D.O.: ☐ Other:
Address:		
City:	State:	ZIP code:
Phone:	Fax:	National Provider Identifier (NPI) number:
Specialty:	Office contact name/Fax attention to:	

Section C: Medical information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (please be specific and provide as much information as possible):	ICD-10 code:

Is this member pregnant? ☐ Yes ☐ No If yes, what is this member's due date?

Member first name:	Member last name:	Member DOB:

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 prescription drug list (PDL) at **UHCprovider.com** for a list of preferred alternatives.

Clinical and drug-specific information

All requests

☐ Yes	☐ No	Has the patient demonstrated history of contraindication, intolerance or allergy to at least 1 of the preferred formulary/PDL alternatives for the given diagnosis? (If yes, complete section D above.)

Member first name:	Member last name:	Member DOB:

Overage limitation medical necessity review		
☐ Yes	☐ No	Does the prescriber attest they are aware of FDA-labeled age limitations regarding the use of the drug and feel the treatment with the requested drug is medically necessary? **If yes**, signature is required and document rationale for use: **Prescriber signature:** **Date:**
Less than FDA minimum age medical necessity review		
☐ Yes	☐ No	Does the prescriber attest they are aware of FDA labeling and feel the treatment with the requested product is medically necessary? **If yes**, signature is required and document rationale for use: **Prescriber signature:** **Date:**

Provider signature:	**Date:**

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