UnitedHealthcare Community Plan

Medication 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.**

Section A - Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP:
Phone:	Date of Birth:	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

Section B - Physician Information				
First Name:		Last Name:		
Address:		City:	State:	ZIP:
Phone:	Fax:	NPI #:	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? _____**
Why wouldn't the preferred medication(s) meet this member's needs? You may fax additional documentation with this form to help us determine medical necessity.	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for Failure or Discontinuation

Physician Signature: _____ Date: _____