UnitedHealthcare Community Plan

EFFIENT

PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:____________________

Is this patient currently hospitalized? □Yes □No

Is the patient residing in a LTC facility? □Yes □No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name: M.D. /D.O.		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication to be Administered: □Physician's Office □Patient's Home □LTC Facility □Other

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

Explanation of why the preferred medication(s) would not meet your patient's needs:

Will the patient be managed with percutaneous coronary intervention (PCI/coronary angioplasty)? YES or **NO**

Does the patient have any of the following: **YES** or **NO** (*circle all that apply below)*

Active pathological bleeding **History of transient ischemic attack or stroke**

Is the patient < 75 years old? YES or NO

Does the patient have one of the following: YES or NO *(circle all that apply below)*

Diabetes **History of prior MI**

Other Medications tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: ____ Date: _______________

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