UnitedHealthcare Community Plan

FULYZAQ

PRIOR AUTHORIZATION REQUEST FORM

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

SECTION A - PATIENT INFORMATION		
Today's Date:	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

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: **Strength:**

Directions for use:

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

SECTION C – CLINICAL INFORMATION

Initial Authorization Requests:

Does the patient have a diagnosis of HIV/AIDS associated diarrhea? ☐ **Yes** ☐ **No**

Have infectious causes of diarrhea been ruled out as the cause of this patient's diarrhea? ☐ **Yes** ☐ **No**

Does this patient have persistently loose stools despite the use of anti-diarrheal medication?
☐ **Yes** ☐ **No**

Does this patient have one or more watery bowel movements per day without regular anti-diarrheal medication use? ☐ **Yes** ☐ **No**

Is this patient currently on antiretroviral therapy? ☐ **Yes** ☐ **No**
If yes, what medications? _____

Re-Authorization Requests:

Has the patient demonstrated a positive clinical response to Fulyzaq therapy? ☐ **Yes** ☐ **No**
Describe benefit of therapy: _____

_____

Physician Signature: _____ **Date:** _____

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Physician Signature: _____ **Date:** _____

Phone: 800-310-6826 Fax: 866-940-7328 Website: www.uhccommunityplan.com