UnitedHealthcare Community Plan

Insulin Pen
PRIOR AUTHORIZATION REQUEST FORM

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

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:				

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific for diabetes please include type I or type II)**:**	**ICD-10 CODE:**
Explanation of why the Member is not able to use a preferred vial and syringe:	
Most recent HbA1c Levels and Dates:	
HbA1c Level:	**Date Drawn:**

Physician Signature: _____ **Date:** _____