UnitedHealthcare Community Plan

LOVAZA

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.**
This form contains 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:
Phone:	DOB:	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: M.D./D.O.	
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			

Section C – Medical Information

Medication:	**DAW: □ Y □ N Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

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

Section D – Clinical Information

- What is the patient's pre-treatment triglyceride level? ____________mg/dL

- Does the patient have a documented positive clinical response to therapy? □ Yes □ No □ New start

- Is the patient on an appropriate lipid-lowering diet and exercise regimen? □ Yes □ No
List details: ____

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Section E – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: ____ Date: __________________

Website: uhccommunityplan.com