

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 Code:
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 code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	Strength:
Dispense as Written: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

Clinical and Drug Specific Information

- Has the patient previously tried a topical corticosteroid? Yes No
(If yes, complete medication information on above table)

- What is the patient's diagnosis?
 - Mild to moderate atopic dermatitis
 - Eczema
 - Psoriasis
 - Other, list: _____

- Will the prescribed medication be applied to the facial or groin area? Yes No

- Does the patient have a history of failure, contraindication or intolerance to topical corticosteroids? Yes No
(If yes, complete medication information on above table)

Physician Signature: _____ **Date:** _____

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.

Website: uhcommunityplan.com