UnitedHealthcare Community Plan

Cough & Cold Products - Hawaii
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 may contain 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 Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider 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:**
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 – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to any preferred cough and cold products?** *(If yes, complete Section D above)*
PATIENTS LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Does the prescriber attest they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary?** *If yes, document rationale for use:*
□ Yes □ No	**Does the patient have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)?** *If yes, list comorbid condition:*
□ Yes □ No	**Has the patient tried and failed any non-opioid containing cough and cold remedy?** *(If yes, complete Section D above)*
QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD	
□ Yes □ No	**Does the prescriber attest that a larger quantity is medically necessary?**
□ Yes □ No	**Does the prescriber attest they are aware of patient's current opioid therapy and morphine milligram equivalent (MME) dose and feels the treatment with the requested product is medically necessary?**

Provider Signature: _____ **Date:** _____