UnitedHealthcare Community Plan

Antidepressants: Serotonin Modulators - Washington
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.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

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

1. Is this a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have documented positive clinical response? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Major Depressive Disorder
   ☐ Other. Specify: _____

3. For patients 17 years of age or younger: Has an agency-designated mental health specialist from the Second Opinion Network (SON) performed a required second opinion review? ☐ Yes ☐ No

4. Has patient tried and failed three preferred antidepressants which are from at least two of the following Apple Health antidepressant subclasses? ☐ Yes ☐ No

   - Alpha-2 Receptor Antagonists (Tetracyclics)
   - Monoamine Oxidase Inhibitors (MAOI)
   - Norepinephrine-Dopamine Reuptake Inhibitors
   - Selective Serotonin Reuptake Inhibitors (SSRI)
   - Selective Serotonin-Norepinephrine Reuptake Inhibitors (SNRI)
   - Tricyclic Agents

5. Indicate all antidepressants patient has tried and failed with reason for discontinuation:
   _____
   _____
   _____

Chart notes are required with this request

Prescriber signature	Prescriber specialty	Date