UnitedHealthcare Community Plan

Antidiabetics: GLP-1 Agonists - 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 request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Type 2 diabetes
   ☐ Type 2 diabetes with established atherosclerotic cardiovascular disease (ASCVD) or risk factors
   ☐ Other. Specify: _____

3. Provide patient's HbA1c for the following:
   Baseline: _____ Date taken: _____
   Current (within last 12 mos.): _____ Date taken: _____

4. List all medications patient has previously tried or has a history of failure, defined as inability to achieve glycemic control or, intolerance and include the duration of use and reason for discontinuation for each medication.
   _____
   _____
   _____

5. List any alternatives that the patient has contraindication to or are clinically inappropriate:
   _____
   _____
   _____

Chart notes and documentation of HbA1c measurements are required with this request

Prescriber signature	Prescriber specialty	Date