UnitedHealthcare Community Plan

Antipsychotics - 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.

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	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?** *If yes, Start Date:* *Discharge Date:*
□ Yes □ No	**Is the patient been receiving treatment with the requested non-preferred agent and is new to the plan (enrollment date within the past 90 days)?** *If yes, List Start Date:*
□ Yes □ No	**Has the patient demonstrated failure or intolerance to any of the preferred formulary/PDL alternatives for the given diagnosis?** *(If yes, complete Section D above)*
□ Yes □ No	**Do both of the following apply to the patient:** *(Check which applies)* □ Trial of two preferred products, other than the generic equivalent to the requested brand □ Trial of the generic equivalent of the product being requested from 5 manufacturers. (If fewer than 5 manufacturers, must try all manufacturers)
REQUESTS TO EXCEED QUANTITY LIMIT	
□ Yes □ No	**Is there a reason why a greater quantity of medication is required to treat the patient's condition?** *If yes, list reasoning:*
THERAPEUTIC DUPLICATION FOR MEMBERS UNDER THE FDA APPROVED AGE	
□ Yes □ No	**Is the patient transitioning from one antipsychotic to another or will the patient remain on both medications?** □ Transitioning from one antipsychotic to another *List drug that will be stopped and date it will be stopped:* □ No, patient will remain on both medications
MENTAL HEALTH POLYPHARMACY	
□ Yes □ No	**Will the patient remain on five or more psychotropic/mental health medications or is the patient titrating/changing medications and will be on less than five psychotropic/mental health medications?** *(If yes, check which applies)* □ Transitioning medications AND will be on LESS THAN five psychotropic medications. *Please list drugs that will be stopped and date of discontinuation:* □ Patient will remain on five or more psychotropic medications
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation of positive clinical response to treatment?** *If yes, list response:*

Provider Signature: _____ **Date:** _____