UnitedHealthcare Community Plan

Exception to Rule (ETR) Request - 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 is for *Washington ETR requests* only, not an appeal request or initial requests)
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

- **Is this an Exception to Rule (ETR) request? ❑ Yes ❑ No** (If yes, Medical records must be submitted supporting this request)

- **Is the requested medication being used for an indication supported by information from the compendia of current literature? ❑ Yes ❑ No**
  If yes, list supporting literature: _____

- **Is the requested medication being used for a condition supported by clinical literature from the physician? ❑ Yes ❑ No** (If yes, must attach clinical literature)

- **Does the prescriber attest that this treatment represents cost-effective use of public funds? ❑ Yes ❑ No**

- **Is the patient's clinical condition so different from the majority that there is no equally effective, less costly covered service or equipment that meets the patient's needs? ❑ Yes ❑ No** (If yes, must attach documentation)

- **Does the prescriber attest that medical treatment or items of service which are covered under the client's Washington apple health program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be one of the following? ❑ Yes ❑ No**
  (check which applies)
  ❑ Medically ineffective in the treatment of the client's condition
  ❑ Inappropriate for that specific client

Provider Signature: _____ **Date:** _____