

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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:		Specialty:
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:		Allergies:	City:	State:	ZIP Code:
<p>Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____</p> <p>Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____</p> <p>Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____</p>					
Medication Information					
Medication:				Strength:	
Directions for use:				Quantity:	
Medication Administered: <input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____					
Clinical Information					
What is the patient's diagnosis for the medication being requested? _____					
ICD-10 Code(s): _____					
Are there any supporting laboratory or test results related to the patient's diagnosis? <i>(Please specify or provide documentation)</i>					
Previous Medication Trials / Contraindications					
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives					
What medication(s) does the patient have a history of failure to? <i>(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)</i>					
What medication(s) does the patient have a contraindication or intolerance to? <i>(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)</i>					
Additional information that may be important for this review					

Patient First name:	Patient Last name:	Patient DOB:
Clinical and Drug Specific Information		
ALL REQUESTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Sudden onset of weak or paralyzed muscles (cataplexy)	
NARCOLEPSY		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a sleep study? <i>(If yes, documentation of sleep study must be submitted)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have symptoms of excessive daytime sleepiness (EDS)?	

Provider Signature: _____ **Date:** _____

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