UnitedHealthcare Community Plan

24 HOUR – URGENT

ATYPICAL ANTIPSYCHOTIC

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____

Is this patient currently hospitalized? □ Yes □ No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

For Therapeutic Duplication Requests:

Is The requested medication being prescribed because the patient is switching from one antipsychotic medication to another?

Yes or No (Circle Answer) If Yes, reason:_____ Is the requested medication being added to current antipsychotic therapy and will the patient remain on both drugs?

Yes or No *(Circle Answer)* If Yes, reason: _____

Is there a reason or special circumstance that the patient will be taking two or more antipsychotic medications?

Yes or No (Circle Answer) If Yes, reason:_____

For Non Preferred Drug Requests:

Did the patient exhibit an inadequate response to previous treatment with all preferred antipsychotics? (Risperidone,ziprasidone,olanzapine, quetiapine)

Yes or No (Circle Answer) If Yes, explain_____

Did the patient exhibit an intolerance or adverse reaction to previous therapy with all preferred antipsychotics? (Risperidone,ziprasidone,olanzapine, quetiapine)

Yes or No (Circle Answer) If Yes, explain_____

For Quanity Limit Requests:

Please provide clinical rationale for the requested quantity:_____

Please attach any additional pertinent clinical evidence to support this request

Other Medications tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____