UnitedHealthcare Community Plan

# Antihyperuricemics - Nebraska
## 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 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 | **Has the patient failed a trial with ONE preferred agent within this drug class?** *(If yes, complete Section D above)* |
| **COLCHICINE** | |
| □ Yes □ No | **Does the patient have a diagnosis of familial Mediterranean fever OR pericarditis?** |
| **ULORIC** | |
| □ Yes □ No | **Is there a clinical reason why allopurinol cannot be used?** *If yes, list reason:* |
| **ZURAMPIC** | |
| □ Yes □ No | **Does the patient have a history of trial and failure with both allopurinol and Uloric?** *(If yes, complete Section D above)* |
| **DUZALLO** | |
| □ Yes □ No | **Does the patient have a history of trial with allopurinol?** *(If yes, complete Section D above)* |

**Provider Signature:** _____ **Date:** _____