UnitedHealthcare
Community Plan

Ulcerative Colitis
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.**

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP:
Phone:	Date of Birth	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _______________

Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information					
First Name:		Last Name:			
Address:		City:	State:		ZIP:
Phone:	Fax:	NPI #:	Specialty:		
Office Contact Name / Fax Attention to:					

Section C - Medical Information

Medication: **Strength:**

Directions for use: **Quantity:**

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

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _______________**

Explain why the preferred medication(s) would not meet your patient's needs:
(Please fax additional documentation with this form to assist with the determination of medical necessity):

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for Failure or Discontinuation

Physician Signature: ____ **Date:** ___________