



A UnitedHealth Group Company

Medication Prior Authorization Request Form

Patients Name: _____

Physician Name: _____

Member #: _____

Specialty: _____

Phone #: (____) _____

Address: _____

Date of Birth: _____

Phone #: (____) _____

Male

Female

FAX #: (____) _____

Requested Medication: _____ Strength: _____

Directions For Use: _____

DIAGNOSIS: _____

Date Patient Started this Medication: _____

NAME OF SPECIFIC DRUGS TRIED AND FAILED: _____

Reason For Non-Formulary Request. (Patient chart notes will be requested if further documentation is necessary)

Requesting Physician Signature: _____ Date: _____

Office Use Only

Approved

Denied

Date Received : _____

Date Received : _____

Date Reviewed: _____

Date Reviewed: _____

Approval Dates: _____ to _____

Reason Denied: _____

Signature: _____

Signature: _____

Physician notified _____ : _____ am/pm

Signature: _____

1) To Prescriber- Complete ENTIRE form, SIGN and return to:

Prescription Solutions
3515 Harbor Blvd.
Costa Mesa, CA 92626
Phone # : 1-800-711-4555
Fax # : 1-800-527-0531
Mail Stop: LC07-286

2) Obtain Member's Pharmacy Name and Phone number.

3) Prescription Solutions will contact prescriber with decision or request for additional information.

4) Once approval is received, prescriber calls in prescription to member's pharmacy.

5) Authorization will be granted for length of therapy, unless otherwise noted.