

Medication Prior Authorization Request Form

UnitedHealthcare Medicaid and Florida Healthy Kids

**To Prescriber: Complete ENTIRE form, SIGN and return to:
Fax: (866) 940-7328**

INJECTABLE DRUGS FAX: (800) 764-4388

Your request cannot be processed without complete information this includes provider specialty and address

Member Name:	Provider name:
Member ID:	Address:
Address:	Phone:
	Fax :
Phone:	Specialty:
Date of Birth:	NPI # (required)

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	
Date patient started medication:	
Name of specific medications tried and failed:	
Reason for Non-Formulary Request (<i>Patient chart notes may be requested if further documentation is necessary</i>):	
Requesting Physician's signature:	Date:
Additional notes/Additional Treatment/Therapies (diet, exercise, physical therapy, pertinent patient data and lab values (if applicable):	

Confidentiality Notice: This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of the document.