UnitedHealthcare®
A UnitedHealth Group Company

# 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 *(Patient chart notes may be requested if further documentation is necessary)*:**

**Requesting Physician's signature:** **Date:**

Additional notes/Additional Treatment/Therapies (diet, exercise, physical therapy, pertinent patient data and lab values (if applicable):