United Healthcare Community Plan

GLP-1 Receptor Agonists - Texas
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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
□ Yes □ No	**Does the patient have a diagnosis of type 2 diabetes?**
□ Yes □ No	**Does the patient have a history of an oral antidiabetic agent for 14 days in the last 365 days?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of the requested medication for 14 days in the last 365 days?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of any of the following?** *(If yes, check which applies)* □ Atherosclerotic cardiovascular disease (ASCVD) □ Chronic kidney disease (CKD) □ Heart failure (HF)
□ Yes □ No	**Does the patient have a history of end stage renal disease (ESRD), pancreatitis, gastroparesis, medullary thyroid carcinoma (MTC), or multiple endocrine neoplasia syndrome type 2 (MEN 2) in the last 730 days?**
□ Yes □ No	**Does the patient have a history of ESRD services (CPT codes) in the last 730 days?**
□ Yes □ No	**Does the patient have a history of a hemoglobin A1c (HbA1c) test in the last 180 days?**
□ Yes □ No	**Will the patient have concurrent therapy with a glucagon-like peptide-1 receptor agonist (GLP-1 RA) containing medication?**

Provider Signature: ______________________________ **Date:** ____________

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