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):