

**PRIOR AUTHORIZATION
REQUEST FORM**

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:

SECTION A - PATIENT INFORMATION

First Name: Juan Last Name: Rodriguez Member ID: 56791377
Address: 1942 Slocum Rd, Dix Hills, NY
City: Dix Hills State: New York Zip: 13295
Phone: 515-739-8864 DOB: 10/17/1992 Allergies: Peanuts
Primary Insurance: United Select Policy #: 574469812 Group #: 2647

Is the requested medication **NEW** ☒ or a **CONTINUATION of THERAPY** ☐? If so, start date: 12/19/21

Is this patient currently hospitalized? ☐ Yes ☒ No

SECTION B - PHYSICIAN INFORMATION

First Name: Samuel Last Name: Charles (M.D./D.O.)
Address: 13 Jericho Ave City: Watertown State: MA Zip: 02838
Phone: 617-744-5556 Fax: 617-744-2295 NPI #: 11134397 Specialty: Dermatology
Office Contact Name / Fax Attention to: Susan Stotomeyer

SECTION C - MEDICAL INFORMATION

Medication: Oxycodone XR Strength: 9,000 Grams
Directions for use: Q6H for severe pain
Diagnosis (Please be specific & provide as much information as possible): cellulitis RLE foot pain
☒ Check here if member has diagnosis of HIV/AIDS

Is this member pregnant? ☐ Yes ☒ No If yes, what is this member's due date?

Explanation of why the preferred medication(s) would not meet your patient's needs (Additional documentation may be faxed with this form to assist with the determination of medical necessity):

Acetaminophen is not strong enough considering this patient's pain is registering a 5 out of 10 and stating "Ouchie, I can't sleep"

Other Medications Tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation
<u>Acetaminophen</u>	<u>500mg</u>	<u>1 tab Q6H for pain</u>	<u>7/7/1999-11/15/2021</u>	<u>Needs stronger medication</u>
<u>Naproxen</u>	<u>200mg</u>	<u>1 tab Q4H for pain</u>	<u>11/15/2021-12/18/2021</u>	<u>Stomach irritation & GI bleed</u>

Physician Signature: [Signature]

Date: 12/18/21

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Website: www.uhccommunityplan.com

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