UnitedHealthcare
Community Plan

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: 617-744-5056 Fax: 617-744-2295	NPI #: 1134397	Specialty: Dermatology	

Office Contact Name / Fax Attention to: Susan Stotomyer

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 **ICD-9 CODE:**

☑ 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
Acetaminophen	500mg	1 tab Q6H for pain	7/7/1999-11/15/2021	Needs stronger medication
Naproxen	200mg	1 tab Q4H for pain	11/15/2021-12/18/2021	Stomach ulceration & GI bleed

Physician Signature: [signature] **Date:** 12/18/21