Prescription Solutions
A UnitedHealth Group Company

Medication Prior Authorization Request Form

Your request cannot be processed without complete information this includes provider specialty and address

Member Name:	Provider name:
Member ID:	Address:
Address:	
	Phone:
Phone:	Fax :
Date of Birth:	Specialty:

Medication: **Strength:**

Directions for use:

Diagnosis*:

Date patient started medication:

Name of specific medications tried and failed:

Reason For Non-Formulary Request. ***(Patient chart notes will be requested if further documentation is necessary)***

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

Additional notes:

To Prescriber- Complete ENTIRE form, SIGN and return to:

Prescription Solutions
M/S CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Phone: 1-800-711-4555

Fax: 1-800-527-0531

******Please call to expedite your request******