

## Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for medication fax request forms.)

### Patient Information

Patient's Name: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Sex:  Male  Female

### Provider Information

Provider's Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Suite Number: \_\_\_\_\_ Building Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

### Medication Information

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Refills: \_\_\_\_\_

### Physician Signature\*\*:

DAW (Initial here): \_\_\_\_\_

**Physician Signature\*\*:** By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

### Medication Instructions

Has the patient been instructed on how to **Self-Administer**?  Yes  No

Is this medication a **New Start**?  Yes  No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

**\*\*Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

### Delivery Instructions

**Note:** Delivery coordination requires a **“Physician Signature”** above and complete **“Provider Information”** and **“Patient Information”**

**Note:** All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

**Ship to:** Physician's Office  Patient's Address  Date medication is needed: / /

Medication Administered: Home Health  Self Administered  LTC  Physician's Office

# ARANESP, EPOGEN, PROCRIT

## PRIOR AUTHORIZATION REQUEST FORM

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

<b>Today's Date</b>			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
<p>Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/>? If so, start date: _____</p> <p>Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name: <span style="float: right;">M.D./D.O.</span>	
Address:		City:	State: <span style="float: right;">Zip:</span>
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
Medication:		Strength:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:
<input type="checkbox"/> Please check here if patient has HIV/AIDS			
<p>Is the patient currently receiving chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check Answer)</p> <p>Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does this patient have Myelodysplastic Syndrome that is transfusion dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No          For patients with Myelodysplastic Syndrome is the patient's serum erythropoietin &lt; 500 mU/mL?  <input type="checkbox"/> Yes <input type="checkbox"/> No If yes provide level and date of result: _____</p> <p>Has the patient received treatment with erythropoietin in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the patient's <u>current</u> hemoglobin AND hematocrit results? <i>Please provide results below.</i>          List hemoglobin and the date of the result: _____ g/dl Date: _____          List hematocrit and the date of the result: _____ % Date: _____</p> <p>Is the patient's hemoglobin and hematocrit being monitored at regular intervals? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, list monitoring frequency if available: _____</p> <p>Is the patient currently receiving iron supplementation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient's iron stores been evaluated? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, did the results indicate that the patient's iron stores are below the normal range? <input type="checkbox"/> Yes <input type="checkbox"/> No          Please provide results below.          Date Drawn: _____          Transferrin saturation: _____ %          Ferritin: _____ ng/mL</p>			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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