

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.uhcprovider.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ Provider ID Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information

Medication: _____ Quantity: _____ ICD10 Code: _____

Directions: _____ Diagnosis: _____ Refills: _____

Physician Signature:** _____ Initial here if DAW: _____

*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 continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? Yes No

****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

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

This form contains multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:

Primary Insurance Information:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:

Office Contact Name / Fax attention to:

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

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

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Bone marrow/stem cell transplant <input type="checkbox"/> Acute myelogenous leukemia (AML) <input type="checkbox"/> Neutropenia associated with cancer chemotherapy-dose dense chemotherapy <input type="checkbox"/> Primary prophylaxis of chemotherapy-induced febrile neutropenia <input type="checkbox"/> Secondary prophylaxis of febrile neutropenia <input type="checkbox"/> Treatment of febrile neutropenia <input type="checkbox"/> Severe chronic neutropenia (SCN) <input type="checkbox"/> HIV-related neutropenia <input type="checkbox"/> Hepatitis-C treatment related neutropenia <input type="checkbox"/> Hematopoietic Syndrome of Acute Radiation Syndrome
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by or in consultation with one of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Hematologist <input type="checkbox"/> Oncologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a reason or special circumstance the patient cannot use any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Neulasta <input type="checkbox"/> Neupogen <input type="checkbox"/> Neulasta Onpro <input type="checkbox"/> Zarxio
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BONE MARROW/STEM CELL TRANSPLANT

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a non-myeloid malignancies?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will this medication be used for the mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient have a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy?

AML INDUCTION or CONSOLIDATION THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient completed induction or consolidation chemotherapy?
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NEUTROPENIA ASSOCIATED WITH CANCER CHEMOTHERAPY- DOSE DENSE CHEMOTHERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown?

PRIMARY PROPHYLAXIS OF CHEMOTHERAPY-INDUCED FEBRILE NEUTROPENIA (FN)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving chemotherapy regimen(s) associated with >20% incidence of febrile neutropenia (FN)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving chemotherapy regimen(s) associated with 10-20% incidence of febrile neutropenia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia? <i>If yes, list risk factors:</i>

SECONDARY PROPHYLAXIS OF FEBRILE NEUTROPENIA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving myelosuppressive anti-cancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3)? <i>List ANC:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of febrile neutropenia during a previous course of chemotherapy?

Member First name:		Member Last name:	Member DOB:
TREATMENT OF FEBRILE NEUTROPENIA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving myelosuppressive anti-cancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3)? <i>List ANC:</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient at high risk for infection-associated complications?		
SEVERE CHRONIC NEUTROPENIA (SCN)			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have congenital, cyclic, or idiopathic neutropenia with chronic ANC less than or equal to 500 cells/mm3? <i>List ANC:</i>		
HIV-RELATED NEUTROPENIA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of HIV infection?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have an ANC (absolute neutrophil count) \leq 1,000 cells/mm3? <i>List ANC:</i>		
HEPATITIS-C TREATMENT RELATED NEUTROPENIA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of Hepatitis C?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)? <i>(If yes, complete Section D above)</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of neutropenia (ANC \leq 500 cells/mm3) after dose reduction of Peg-Intron or Pegasys? <i>List ANC:</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of interferon-induced neutropenia (ANC less than or equal to 500 cells/mm3) due to treatment with Peg-Intron (peginterferon alfa-2B) or Pegasys (peginterferon alfa-2a)? <i>List ANC:</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of HIV co-infection?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient status post liver transplant?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of established cirrhosis?		
HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been acutely exposed to myelosuppressive doses of radiation?		

Physician Signature: _____ Date: _____

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