UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

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 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 ☐

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ORAL CHEMOTHERAPY
PRIOR AUTHORIZATION REQUEST

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

SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____
Is this patient currently hospitalized? □Yes □No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:** **Frequency of Dosage:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-9 CODE:**

Is the requested agent being used as first line therapy? Yes or No *(circle Answer)*
If No, please fill out the following table (Please include both Oral and IV therapies):

Previous Medication Regimens:

Drug Name, Strength, and Directions for Use	Dates of Therapy	Reason for Discontinuing Therapy

Will the requested product be used alone or in combination with another agent? _____
If being used as part of combination therapy please list chemotherapy regimen: _____
_____

Affinitor Requests:
Is the patient's condition unresectable, locally advanced, or metastatic? Yes or No *(Circle answer)*

Hycamtin Requests: *(Circle answer)*
Has at least 45 days passed since the end of the patient's treatment with first line chemotherapy? Yes or No

Temodar Requests:
Temodar be used with radiotherapy? Yes_ or__ No___*(Circle answer)*

Tykerb Requests:
Is the Patient post-menopausal? Yes or No *(Circle Answer)*

Xeloda or Gleevec Requests:
Has the patient undergone complete resection of the primary tumor? Yes___ No___ *(Circle answer)*

If this is a request for reauthorization, has this patient benefited from current therapy? Yes or No *(Circle answer)*

Additional clinical information to support this request:

Physician Signature: _____ Date: _____