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.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 ☐

UnitedHealthcare Community Plan

Cytokine and CAM Antagonists - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

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

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Cytokine and CAM Antagonists - Pennsylvania

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Active psoriatic arthritis □ Ankylosing spondylitis □ Chronic moderate to severe plaque psoriasis □ Crohn's disease □ Giant cell arteritis □ Moderate to severe active rheumatoid arthritis □ Moderate to severe ulcerative colitis □ Other spondyloarthritis
□ **Yes** □ **No**	**Is the prescribed dose appropriate for the patient's age, weight, concurrent medications, liver function, and renal function in accordance with the package labeling?**
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with a specialist (i.e. gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, etc.,)?**
□ **Yes** □ **No**	**Is the patient up to date on immunizations prior to initiating therapy**?
□ **Yes** □ **No**	**Is the patient taking any other cytokine and CAM (Cell-Adhesion Molecule) antagonist?**
□ **Yes** □ **No**	**Will the patient be taking a medication that interacts with the prescribed cytokine and CAM antagonist as recommended in the package labeling?**
□ **Yes** □ **No**	**Does the patient have a contraindication to the prescribed cytokine and CAM antagonist?**
□ **Yes** □ **No**	**Does the patient have documentation of baseline lab results as recommended in the package labeling?** *If yes, list baseline lab results:*
□ **Yes** □ **No**	**Was the patient evaluated for active or latent tuberculosis infection documented by either test results (purified protein derivative [PPD] testing) or blood testing?**
□ **Yes** □ **No**	**Does the patient have active, severe uncontrolled infection?**
□ **Yes** □ **No**	**Does the patient have documentation of completion of hepatitis B immunization series?**
□ **Yes** □ **No**	**Does the patient have documentation of hepatitis B screening (sAb/sAg and cAb) with any of the following?** *(If yes, check which applies)* □ If screening results indicate a risk of hepatitis B virus reactivation (HBVr), a follow-up plan to address this risk □ If negative for hepatitis B, a plan for vaccination against hepatitis B virus
□ **Yes** □ **No**	**Does the patient have acute hepatitis B?**
□ **Yes** □ **No**	**Does the patient have chronic hepatitis B with Child-Pugh class B or C?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure of, or contraindication or intolerance to the preferred cytokine and CAM antagonists approved for the patient's indication (see PA preferred drug list, "Cytokine and CAM Antagonists" section)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient current history (within the past 90 days) of being prescribed the same non-preferred cytokine and CAM antagonist?**
	UNDER 21 YEARS OF AGE
□ **Yes** □ **No**	**Is the patient up to date on immunizations in accordance with current Early and Periodic Screening Diagnosis and Treatment (EPSDT) immunization guidelines prior to initiating therapy?**
	ANKYLOSING SPONDYLITIS / OTHER SPONDYLOARTHRITIS / ACTIVE PSORIATIC ARTHRITIS (cont'd on next page)
□ **Yes** □ **No**	**Does the patient have axial disease and any of the following?** *(If yes, check which applies and complete Section D above)* □ A documented history of therapeutic failure of one (1) month trial of continuous treatment with two (2) different oral non-steroidal anti-inflammatory drugs (NSAIDs) (i.e., an oral NSAID taken on a daily basis for one month and a different oral NSAID taken on a daily basis for one month) □ A documented contraindication or intolerance to oral NSAIDs

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Cytokine and CAM Antagonists - Pennsylvania

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Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Does the patient have peripheral disease and any of the following?** *(If yes, check which applies and complete Section D above)* □ A documented history of therapeutic failure of a one (1) month trial of continuous treatment with two (2) different oral NSAIDs □ A documented history of therapeutic failure of an eight (8) or more week trial of optimally-titrated doses of methotrexate OR an alternate conventional non-biologic DMARD □ A documented contraindication or intolerance to NSAIDs, methotrexate, or an alternate conventional non-biologic DMARD
CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS	
□ Yes □ No	**Does the patient have a body surface area (BSA) with any of the following?** *(If yes, select which applies)* □ 5% or more that is affected □ Involvement of < 5% in critical areas (palms, soles, genitals or face) that interferes with daily activities
□ Yes □ No	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to phototherapy in accordance with current consensus guidelines?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication or intolerance to a trial of oral systemic therapy (e.g., methotrexate, cyclosporine, acitretin)?** *(If yes, complete Section D above)*
CROHN'S DISEASE / MODERATE TO SEVERE ULCERATIVE COLITIS	
□ Yes □ No	**Does the patient have a diagnosis of Crohn's Disease or Ulcerative Colitis which has remained active despite treatment with any of the following therapies?** *(If yes, check which applies and complete Section D above)* □ Aminosalicylates □ Corticosteroids □ Immunomodulators in accordance with current consensus guidelines
GIANT CELL ARTERITIS	
□ Yes □ No	**Does any of the following apply to the patient?** *(If yes, check which applies and complete Section D above)* □ Patient has a documented history of therapeutic failure, contraindication, or intolerance to methotrexate □ Patient will be using the requested medication in combination with a tapering course of glucocorticoids
MODERATE TO SEVERE ACTIVE RHEUMATOID ARTHRITIS	
□ Yes □ No	**Does the patient have a documented history of therapeutic failure of a three (3) or more month trial of or a documented contraindication or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Methotrexate □ An alternate conventional non-biologic disease-modifying anti-rheumatic drug (DMARD) in accordance with current consensus guidelines
COSENTYX	
□ Yes □ No	**Does the patient have a documented history of therapeutic failure of, or contraindication or intolerance to Humira (adalimumab)?** *(If yes, complete Section D above)*
ENTYVIO	
□ Yes □ No	**Has the patient had baseline LFTs (liver function test's) and testing for anti-JC (John Cunningham) virus antibodies?**
□ Yes □ No	**Does the patient have jaundice or elevated transaminases and/or bilirubin?**
□ Yes □ No	**Has the patient ever taken Tysabri (natalizumab)?**
ILUMYA / SKYRIZI / TALTZ / TREMFYA	
□ Yes □ No	**Has the patient had a mental health evaluation?**
KEVZARA	
□ Yes □ No	**Does the patient have active hepatic disease or hepatic impairment?**
OTEZLA	
□ Yes □ No	**Was the patient evaluated by a psychiatrist in the past 6 months if the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder?**
□ Yes □ No	**Is the patient regularly monitored for weight loss?**

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SILIQ	
□ Yes □ No	**Was the patient evaluated by a psychiatrist in the past 6 months if the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder?**
□ Yes □ No	**Is Siliq prescribed by a prescriber enrolled in the Siliq REMS program?**
□ Yes □ No	**Is the patient authorized to receive Siliq by the Siliq REMS program?**
XELJANZ / XELJANZ XR	
□ Yes □ No	**Does the patient have severe hepatic impairment?**
ALL CONTINUATION OF THERAPY REQUESTS (also complete drug specific section, if applicable)	
□ Yes □ No	**Has the patient had an improvement in disease activity and/or level of functioning?**
□ Yes □ No	**Does the patient have documentation of results of recent lab monitoring as recommended in the package labeling?**
□ Yes □ No	**Is the patient continued on the prescribed Cytokine and CAM (Cell-Adhesion Molecule) antagonist based on recent lab results as recommended in the package labeling?**
CONTINUATION OF THERAPY - ENTYVIO	
□ Yes □ No	**If baseline testing for anti-JC (John Cunningham) virus was negative, has the patient had repeat testing for anti-JC virus antibodies?**
CONTINUATION OF THERAPY - OTEZLA	
□ Yes □ No	**Does the patient have documentation of regular weight monitoring?**
□ Yes □ No	**If positive for a history of prior suicide attempt, bipolar disorder, major depressive disorder, does the patient continue to receive treatment for that condition?**
CONTINUATION OF THERAPY - SILIQ	
□ Yes □ No	**If positive for a history of prior suicide attempt, bipolar disorder, major depressive disorder, does the patient continue to receive treatment for that condition?**

Physician Signature: _____ **Date:** _____