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 ☐

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UnitedHealthcare Community Plan

**Actemra**

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**

UnitedHealthcare Community Plan

**Actemra**

PRIOR AUTHORIZATION REQUEST FORM

| 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)*<br>□ Moderately to Severely Active Rheumatoid Arthritis (RA)<br>□ Giant Cell Arteritis<br>□ Moderately to Severely Active Polyarticular Juvenile Idiopathic Arthritis<br>□ Active Systemic Juvenile Idiopathic Arthritis (SJIA) |
| □ **Yes** □ **No** | **Will the patient receive Actemra in combination with any of the following?** *(If yes, check which applies)*<br>□ Biologic DMARD [e.g., Enbrel, Humira, Cimzia, Simponi]<br>□ Janus kinase inhibitor [e.g., Xeljanz]<br>□ Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla] |
| □ **Yes** □ **No** | **Does the patient have history of failure, contraindication, or intolerance to any of the following?**<br>*(If yes, please check which applies and complete section D above)*<br>□ Cimzia (certolizumab)<br>□ Humira (adalimumab)<br>□ Enbrel (etanercept)<br>□ Kevzara (sarilumab)<br>□ Olumiant (baricitinib) |
| **RHEUMATOID ARTHRITIS** | |
| □ **Yes** □ **No** | **Does the patient have a history of failure, contraindication, or intolerance to any non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine]?** *(If yes, complete Section D above)* |
| **GIANT CELL ARTERITIS** | |
| □ **Yes** □ **No** | **Does the patient have a history of failure, contraindication, or intolerance to one glucocorticoid (e.g., prednisone)?** *(If yes, complete Section D above)* |
| **CONTINUATION OF THERAPY** | |
| □ **Yes** □ **No** | **Does the patient have a documented positive clinical response to Actemra therapy?**<br>*If yes, list positive response:* |

**Physician Signature:** ______________________________________________ **Date:** ____________________

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