

## 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

# ACTHAR GEL

## PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date \_\_\_\_\_

**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:	M.D./D.O.
Address:		City: State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		

Medication to be Administered:  Physician's Office  Patient's Home  Other

**SECTION C - MEDICAL INFORMATION**

Medication: \_\_\_\_\_

Directions for use: \_\_\_\_\_

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

**For Diagnoses other than Infantile Seizures or Opsoclonus-Myoclonus Syndrome Please Provide Additional Documentation Requested Below:**

**Does the patient have a history of failure, contraindication, or intolerance to conventional therapy, including corticosteroids for chronic/maintenance treatment of the patient's condition? Yes or No (Circle answer)**

If yes, please provide additional details: \_\_\_\_\_

\_\_\_\_\_

Other Medications tried				
Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

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