

**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](http://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 for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<b>Clinical and Drug Specific Information</b>		
<b>ALL REQUESTS</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a diagnosis of hereditary angioedema (HAE) as confirmed by any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene <input type="checkbox"/> A C4 level below the lower limit of normal and one of the following (per laboratory standard): C1 inhibitor (C1-INH) antigenic level below the lower limit of normal OR C1-INH functional level below the lower limit of normal	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will Cinryze be used for any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Prophylaxis against HAE attacks <input type="checkbox"/> Treatment of acute HAE attacks	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will Cinryze be used in combination with other approved C1 esterase inhibitors indicated for prophylaxis against HAE attacks (e.g., Haegarda)?</b> <i>If yes, list medication and rationale:</i>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the prescriber attest that the patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will Cinryze be used in combination with other approved treatments for acute HAE attacks (e.g. Berinert, Firazyr, Kalbitor or Ruconest)?</b> <i>If yes, list medication and rationale:</i>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is Cinryze prescribed by one of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Immunologist <input type="checkbox"/> Allergist <input type="checkbox"/> Rheumatologist	

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

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