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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Colony Stimulating Factors

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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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 any of the following diagnoses?** *(If yes, check which applies)* □ Bone marrow/stem cell transplant □ Acute myeloid leukemia (AML) □ Neutropenia associated with cancer chemotherapy-dose dense chemotherapy □ Primary prophylaxis of chemotherapy-induced febrile neutropenia □ Secondary prophylaxis of febrile neutropenia □ Treatment of febrile neutropenia □ Severe chronic neutropenia (SCN) □ HIV-related neutropenia □ Hepatitis-C treatment related neutropenia □ Hematopoietic Syndrome of Acute Radiation Syndrome
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Hematologist □ Oncologist □ Gastroenterologist □ Hepatologist □ Infectious Disease Specialist
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following medication?** *(If yes, complete Section D above)* □ Zarxio □ Neulasta
□ **Yes** □ **No**	**<u>If patient had a previous trial of Neulasta</u>, does the physician attest that in their clinical response would be expected to be superior with the requested medication than experienced with Neulasta?**
□ **Yes** □ **No**	**<u>If patient had a previous trial of Zarxio,</u> does the physician attest that in their clinical response would be expected to be superior with the requested medication than experienced with Zarxio?**
	BONE MARROW/STEM CELL TRANSPLANT
□ **Yes** □ **No**	**Does the patient have non-myeloid malignancies?**
□ **Yes** □ **No**	**Is the patient undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)?**
□ **Yes** □ **No**	**Will this medication be used for the mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis?**
□ **Yes** □ **No**	**Did the patient have a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy?**
	ACUTE MYELOID LEUKEMIA (AML) or CONSOLIDATION THERAPY
□ **Yes** □ **No**	**Has the patient completed induction or consolidation chemotherapy?**
	NEUTROPENIA ASSOCIATED WITH CANCER CHEMOTHERAPY- DOSE DENSE CHEMOTHERAPY
□ **Yes** □ **No**	**Is the patient receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer?**
□ **Yes** □ **No**	**Is the patient receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown?**
	PRIMARY PROPHYLAXIS OF CHEMOTHERAPY-INDUCED FEBRILE NEUTROPENIA (FN)
□ **Yes** □ **No**	**Is the patient receiving a chemotherapy regimen associated with >20% incidence of febrile neutropenia (FN)?**
□ **Yes** □ **No**	**Is the patient receiving a chemotherapy regimen associated with 10-20% incidence of febrile neutropenia?**
□ **Yes** □ **No**	**Does the patient have any risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia?** *If yes, list risk factors:*

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Member First name:	Member Last name:	Member DOB:

	SECONDARY PROPHYLAXIS OF FEBRILE NEUTROPENIA
□ Yes □ No	**Is the patient receiving myelosuppressive anti-cancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3)?**
□ Yes □ No	**Does the patient have a history of febrile neutropenia during a previous course of chemotherapy?**
	TREATMENT OF FEBRILE NEUTROPENIA
□ Yes □ No	**Is the patient receiving myelosuppressive anti-cancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3)?**
□ Yes □ No	**Is the patient at high risk for infection-associated complications?**
	SEVERE CHRONIC NEUTROPENIA (SCN)
□ Yes □ No	**Does the patient have congenital, cyclic, or idiopathic neutropenia with chronic ANC less than or equal to 500 cells/mm3?** *List ANC:*
	HIV-RELATED NEUTROPENIA
□ Yes □ No	**Does the patient have a diagnosis of HIV infection?**
□ Yes □ No	**Does the patient have an ANC (absolute neutrophil count) ≤ 1,000 cells/mm3?** *List ANC:*
	HEPATITIS-C TREATMENT RELATED NEUTROPENIA
□ Yes □ No	**Does the patient have a diagnosis of Hepatitis C?**
□ Yes □ No	**Is the patient undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)?** *(If yes, complete Section D above)*
□ Yes □ No	**Is their documentation of neutropenia (ANC ≤ 500 cells/mm3) after dose reduction of Peg-Intron or Pegasys?** *List ANC:*
□ Yes □ No	**Is there documentation of interferon-induced neutropenia (ANC less than or equal to 500 cells/mm3) due to treatment with Peg-Intron (peginterferon alfa-2B) or Pegasys (peginterferon alfa-2a)?** *List ANC:*
□ Yes □ No	**Does the patient have a diagnosis of HIV co-infection?**
□ Yes □ No	**Is the patient status post liver transplant?**
□ Yes □ No	**Does the patient have a diagnosis of established cirrhosis?**
	HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME
□ Yes □ No	**Has the patient been acutely exposed to myelosuppressive doses of radiation?**

Physician Signature: _____ **Date:** _____