

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

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**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have any of the following diagnoses? <i>(check which apply)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Advanced Renal Cell Carcinoma <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Classical Hodgkin Lymphoma <input type="checkbox"/> Endometrial Carcinoma <input type="checkbox"/> Follicular carcinoma <input type="checkbox"/> Gastrointestinal Stromal Tumor (GIST) <input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Hürthle cell carcinoma <input type="checkbox"/> Lymphangi leiomyomatosis <input type="checkbox"/> Lymphoplasmacytic Lymphoma <input type="checkbox"/> Meningioma <input type="checkbox"/> Neuroendocrine Tumors <input type="checkbox"/> Papillary carcinoma <input type="checkbox"/> PEComa (perivascular epithelioid cell tumor) </td> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Recurrent angiomyolipoma <input type="checkbox"/> Renal Angiomyolipoma and Tuberous Sclerosis Complex (TSC) <input type="checkbox"/> Renal Cell Cancer <input type="checkbox"/> Soft Tissue Sarcoma <input type="checkbox"/> Subependymal Giant Cell Astrocytoma (SEGA) with Tuberous Sclerosis Complex <input type="checkbox"/> Thymic Carcinoma <input type="checkbox"/> Thymoma <input type="checkbox"/> Thyroid Carcinoma <input type="checkbox"/> Tuberous Sclerosis Complex associated Partial-Onset Seizures <input type="checkbox"/> Waldenström’s Macroglobulinemia </td> </tr> </table>	<input type="checkbox"/> Advanced Renal Cell Carcinoma <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Classical Hodgkin Lymphoma <input type="checkbox"/> Endometrial Carcinoma <input type="checkbox"/> Follicular carcinoma <input type="checkbox"/> Gastrointestinal Stromal Tumor (GIST) <input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Hürthle cell carcinoma <input type="checkbox"/> Lymphangi leiomyomatosis <input type="checkbox"/> Lymphoplasmacytic Lymphoma <input type="checkbox"/> Meningioma <input type="checkbox"/> Neuroendocrine Tumors <input type="checkbox"/> Papillary carcinoma <input type="checkbox"/> PEComa (perivascular epithelioid cell tumor)	<input type="checkbox"/> Recurrent angiomyolipoma <input type="checkbox"/> Renal Angiomyolipoma and Tuberous Sclerosis Complex (TSC) <input type="checkbox"/> Renal Cell Cancer <input type="checkbox"/> Soft Tissue Sarcoma <input type="checkbox"/> Subependymal Giant Cell Astrocytoma (SEGA) with Tuberous Sclerosis Complex <input type="checkbox"/> Thymic Carcinoma <input type="checkbox"/> Thymoma <input type="checkbox"/> Thyroid Carcinoma <input type="checkbox"/> Tuberous Sclerosis Complex associated Partial-Onset Seizures <input type="checkbox"/> Waldenström’s Macroglobulinemia
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?</p> <p><i>If yes, list supported use:</i></p>
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NEURIENDOCRINE TUMORS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have one of the following diagnoses? <i>(check which apply)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Neuroendocrine tumors of pancreatic origin <input type="checkbox"/> Neuroendocrine tumors of lung origin </td> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Neuroendocrine tumors of gastrointestinal origin <input type="checkbox"/> Neuroendocrine tumors of thymic origin </td> </tr> </table>	<input type="checkbox"/> Neuroendocrine tumors of pancreatic origin <input type="checkbox"/> Neuroendocrine tumors of lung origin	<input type="checkbox"/> Neuroendocrine tumors of gastrointestinal origin <input type="checkbox"/> Neuroendocrine tumors of thymic origin
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient’s disease progressive?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have unresectable, locally advanced, or metastatic disease?</p>
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ADVANCED RENAL CELL CANCER

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient’s disease relapsed?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a medically or surgically unresectable tumor?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a diagnosis of Stage IV disease?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have non-clear cell histology?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have predominantly clear cell histology?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to at least one prior tyrosine kinase inhibitor therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)]?</p> <p><i>(If yes, complete Section D above)</i></p>
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RENAL ANGIOMYOLIPOMA AND TUBEROUS SCLEROSIS COMPLEX (TSC)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient require immediate surgery?</p>
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SUBEPENDYMAL GIANT CELL ASTROCYTOMA

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient a candidate for curative surgical resection?</p>
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WALDENSTRÖM’S MACROGLOBULINEMIA OR LYMPHOPLASMACYTIC LYMPHOMA

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does one of the following apply to the patient? <i>(check which apply)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Disease is non-responsive to primary treatment <input type="checkbox"/> Disease has relapsed </td> <td style="width:50%; border: none; vertical-align: top;"> <input type="checkbox"/> Disease is progressive </td> </tr> </table>	<input type="checkbox"/> Disease is non-responsive to primary treatment <input type="checkbox"/> Disease has relapsed	<input type="checkbox"/> Disease is progressive
<input type="checkbox"/> Disease is non-responsive to primary treatment <input type="checkbox"/> Disease has relapsed	<input type="checkbox"/> Disease is progressive		

BREAST CANCER

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient’s disease recurrent or metastatic?</p>
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Member First name:		Member Last name:	Member DOB:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient's disease hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have hormone receptor negative (HR-) disease?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the disease have clinical characteristics that predict an HR+ tumor?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient postmenopausal or premenopausal? <i>(check which applies)</i> <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Premenopausal		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being treated with ovarian ablation/suppression?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Afinitor be used in combination with any of the following? <i>(check which applies)</i> <input type="checkbox"/> Aromasin (exemestane) <input type="checkbox"/> Faslodex (Fulvestrant) <input type="checkbox"/> Tamoxifen		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient's disease progressed while on or within 12 months of non-steroidal aromatase inhibitor therapy [e.g., Arimidex (anastrozole), Femara (letrozole)]? <i>(If yes, complete Section D above)</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been treated with tamoxifen at any time? <i>(If yes, complete Section D above)</i>		
HODGKIN LYMPHOMA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have relapsed or refractory disease?		
SOFT TISSUE SARCOMA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the disease progressed after single agent therapy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Afinitor be used in combination with <u>one</u> of the following: <i>(check which applies)</i> <input type="checkbox"/> Gleevec (imatinib) <input type="checkbox"/> Sutent (sunitinib) <input type="checkbox"/> Stivarga (regorafenib)		
BONE CANCERS – THYMOMAS - THYMIC CARCINOMAS			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to at least <u>one</u> prior first-line chemotherapy regimen? <i>(If yes, complete Section D above)</i>		
THYROID CARCINOMA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following? <i>(check which applies)</i> <input type="checkbox"/> Unresectable locoregional recurrent <input type="checkbox"/> Persistent <input type="checkbox"/> Metastatic		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have symptomatic or progressive disease?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the disease refractory to radioactive iodine treatment?		
MENINGIOMA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have recurrent or progressive disease?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is surgery and/or radiation not possible?		
ENDOMETRIAL CARCINOMA			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Afinitor be used in combination with letrozole?		
TUBEROUS SCLEROSIS COMPLEX ASSOCIATED PARTIAL-ONSET SEIZURES			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Afinitor be used as adjunctive therapy? <i>If yes, list:</i>		
CONTINUATION OF THERAPY			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient show evidence of progressive disease while on Afinitor therapy? <i>If yes, list response:</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented positive clinical response to Afinitor therapy? <i>If yes, list response:</i>		

Physician Signature: _____ Date: _____

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