UnitedHealthcare Community Plan

Atopic Dermatitis Agents, Monoclonal Antibodies - Washington

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 may contain 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 (if any):		

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

Medication Name	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

UnitedHealthcare Community Plan

Atopic Dermatitis Agents, Monoclonal Antibodies - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- Does the patient have a diagnosis of severe chronic atopic dermatitis involving at least 10% of body surface area (BSA)? □ Yes □ No
If no, list diagnosis: _____

- Is there clinical documentation of functional impairment due to atopic dermatitis, which may include (but is not limited to) documentation of limitation of activities of daily living (ADLs), skin infections or sleep disturbances? □ Yes □ No
If yes, list what patient meets: _____
_____

- Does the patient have a history of failure (unable to achieve or maintain remission of low or mild disease), intolerance, contraindication or clinically inappropriate to daily use of the following: failure of 2 high or very high potency corticosteroids in the previous 6 months for at least 14 days each, unless the patient has contraindication(s) to all preferred topical corticosteroids? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a history of failure (unable to achieve or maintain remission of low or mild disease), intolerance, contraindication or clinically inappropriate to daily use of the following: topical calcineurin inhibitors (e.g. pimecrolimus, tacrolimus) daily treatment for at least 28-days? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a history of failure (unable to achieve or maintain remission of low or mild disease), intolerance, contraindication or clinically inappropriate to daily use of one of the following: □ Yes □ No (check which applies)
□ Phototherapy
□ Systemic treatment with immunosuppressants (such as methotrexate, cyclosporine, azathioprine, mycophenolate)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Was the medication prescribed by or in consultation with a specialist in dermatology, allergy or pulmonology? □ Yes □ No

Requests for CONTINUATION OF THERAPY:

- Is there documentation of decrease in BSA involvement and resolution of associated symptoms (e.g. pruritus, inflammation, redness, etc)? □ Yes □ No

Provider Signature: _____ Date: _____