

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 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 - Physician 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:
--------------------	-------------------	-------------

Clinical and Drug Specific Information

ALL REQUESTS:

- Does the patient have a diagnosis of Type 1 Gaucher's disease? Yes No
 If yes, is it mild to moderate? Yes No
 If no, list diagnosis: _____

- If the patient has a diagnosis of Type 1 Gaucher's disease, has the disease resulted in one or more of the following: Yes No (check all that apply)
 - Anemia
 - Thrombocytopenia
 - Bone disease
 - Hepatomegaly or splenomegaly

- Does the patient have a history of failure, contraindication, or intolerance to Cerezyme? Yes No
 (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for CERDELGA:

- Is the patient one of the following, as detected by an FDA-cleared test: Yes No (check which applies)
 - CYP2D6 extensive metabolizer
 - CYP2D6 intermediate metabolizer
 - CYP2D6 poor metabolizer

Requests for ZAVESCA:

- Is the patient unable to receive enzyme replacement therapy due to one of the following conditions: Yes No (check which applies)
 - Allergy or hypersensitivity to enzyme replacement therapy
 - Poor venous access
 - Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)

Requests for CONTINUATION OF THERAPY:

- Does the patient have a documented positive clinical response to therapy? Yes No
 If yes, list response: _____

Physician Signature: _____ **Date:** _____

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.