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.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: DAW (Initial here):

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 **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****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 ☐

UnitedHealthcare Community Plan

Exjade

URGENT – 24 Hour Request

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____________

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:		
Office Contact Name / Fax Attention to:				

Drug Requested:

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 Code:**

Does this patient have chronic iron overload? YES or NO (Circle Answer)

- **If YES: What is the patient's chronic iron overload caused by: (check appropriate answer)**
  - ☐ **Blood transfusions (proceed to "Blood Transfusions Questions")**
  - ☐ **Non-transfusion dependent thalassemia syndrome (proceed to "Non-transfusion Dependent Thalassemia Syndrome Questions)**

Blood Transfusions Questions: (If renewal please proceed to Renewal of Authorization Section)

- **Has the patient had at least 100 ml/kg of packed red blood cells prior to initiation of treatment with Exjade?**
  YES or NO (Circle Answer)
- **Is the patient's serum ferritin level consistently greater than 1,000 mcg/L prior to initiation of therapy with Exjade?**
  YES or NO (Circle Answer)
  List serum ferritin level: ___________________ Date Drawn: ____________________
- **Is this patient unable to comply or adhere to injectable Desferal therapy? YES or NO (Circle Answer)**
- **What is the prescriber's specialty? ____**

Non-Transfusion Dependent Thalassemia Syndrome Questions: (If renewal please proceed to Renewal of Authorization Section)

- **Is the patient's liver iron (Fe) concentration (LIC) consistently greater than or equal to 5 mg FE per gram of dry weight prior to initiation of treatment with Exjade? YES or NO (Circle Answer)**
- **Is the patient's serum ferritin level consistently greater than 1,000 mcg/L prior to initiation of therapy with Exjade?**
  YES or NO (Circle Answer)
  List serum ferritin level: ___________________ Date Drawn: ____________________

Renewal of Authorization Section:

Has the patient shown positive clinical response to Exjade therapy? YES or NO (Circle Answer) Provide details:____

Physician Signature: ____ Date: ________________