UnitedHealthcare Community Plan

URGENT – 24 HOURS

GILENYA

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 #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD 10 Code:**

SECTION C – CLINICAL INFORMATION

Does the patient have a diagnosis of a relapsing form of multiple sclerosis? ☐ **Yes** ☐ **No**

Does the patient have a history of failure following a trial of at least 4 weeks or a history of intolerance to one of the following disease modifying therapies for MS: Avonex, Rebif, Extavia, Betaseron, Copaxone)?

☐ **Yes** ☐ **No**

If yes, list medication(s) tried and date(s) of therapy: _____

_____

Does the patient have a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure? ☐ **Yes** ☐ **No**

Additional clinical information to support this request:

_____

_____

Physician Signature: _____ **Date:** _____