

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 at www.uhcprovider.com 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	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Adjunct for gender-affirming hormonal therapy for transgender adults <input type="checkbox"/> Advanced or metastatic prostate cancer <input type="checkbox"/> Central precocious puberty (idiopathic or neurogenic) <input type="checkbox"/> Endometriosis or endometriosis is suspected <input type="checkbox"/> Fertility preservation <input type="checkbox"/> Gender dysphoria in adolescents <input type="checkbox"/> Infertility <input type="checkbox"/> Uterine leiomyomata (fibroids)
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ADJUNCT FOR GENDER-AFFIRMING HORMONAL THERAPY FOR TRANSGENDER ADULTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax? <i>(Documentation required)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have the patient's gonads (i.e., testes, ovaries) been removed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's gonads functional (e.g., hormone producing)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there an inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i> <ul style="list-style-type: none"> • Transgender patient has identified goals of gender-affirming hormone therapy • Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed • Current enrollment, attendance, and active participation in psychological and social support treatment program • Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment • Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

CENTRAL PRECOCIOUS PUBERTY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the onset of secondary sexual characteristics occur in the patient at one of the following ages? <i>(If yes, check which applies)</i> <input type="checkbox"/> ≤ 8 years of age in females <input type="checkbox"/> ≤ 9 years of age in males
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the diagnosis confirmed by any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> A pubertal luteinizing hormone response to a GnRH stimulation test <input type="checkbox"/> Bone age advanced one year beyond the chronological age <input type="checkbox"/> Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)
<input type="checkbox"/> Yes <input type="checkbox"/> No	For <u>Triptodur requests</u>, does the patient have a history of failure, contraindication, or intolerance to Lupron-Depot Ped? <i>(If yes, complete Section D above)</i>

ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED *(Continued on next page)*

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Non-steroidal anti-inflammatory drugs (NSAIDs) <input type="checkbox"/> Oral contraceptives or depot medroxyprogesterone (e.g., Depo- Provera)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had surgical ablation to prevent recurrence?

Member First name:		Member Last name:		Member DOB:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	For Lupaneta Pack requests , does the patient have a history of failure, contraindication, or intolerance to Lupron Depot? <i>(If yes, complete Section D above)</i>				
FERTILITY PRESERVATION					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication for use in a pre-menopausal woman?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]?				
GENDER DYSPHORIA IN ADOLESCENTS					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax? <i>(Documentation required)</i>				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced puberty development to at least Tanner stage 2?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have laboratory tests, based upon the laboratory reference range, confirming any of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> A pubertal luteinizing hormone response to a GnRH stimulation test <input type="checkbox"/> Pubertal basal level of luteinizing hormone (based on laboratory reference ranges) <input type="checkbox"/> Pubertal levels of estradiol in females <input type="checkbox"/> Pubertal levels of testosterone in males 				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i></p> <ul style="list-style-type: none"> • Patient has experienced pubertal changes that have resulted in an increase of their gender dysphoria that has significantly impaired psychological or social functioning • Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed • Current enrollment, attendance, and active participation in psychological and social support treatment program • Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment • Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 				
UTERINE LEIOMYOMATA (FIBROIDS)					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this request for the treatment of uterine leiomyomata-related anemia?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient respond to 1 month of iron therapy?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used prior to surgery?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)?				
CONTINUATION OF THERAPY - ADJUNCT FOR GENDER-AFFIRMING HORMONAL THERAPY FOR TRANSGENDER ADULTS <i>(Continued on next page)</i>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax? <i>(Documentation required)</i>				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a change in dosing?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's gonads (i.e., testes, ovaries) intact?				

Member First name:	Member Last name:	Member DOB:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i> <ul style="list-style-type: none"> • Transgender patient continues to meet goals of gender-affirming hormone therapy • Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment continue to be addressed or removed • Current enrollment, attendance, and active participation in psychological and social support treatment program • Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment • Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 	
CONTINUATION OF THERAPY - CENTRAL PRECOCIOUS PUBERTY (CPP)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving therapy for central precocious puberty?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of positive clinical response to therapy?	
CONTINUATION OF THERAPY - ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced a recurrence of symptoms following an initial course of therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used concurrently with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)? <i>If yes, list add-back therapy:</i>	
CONTINUATION OF THERAPY - FERTILITY PRESERVATION		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving GnRH analog therapy for the purpose of fertility preservation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient continue to receive a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]?	
CONTINUATION OF THERAPY - GENDER DYSPHORIA IN ADOLESCENTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax? <i>(Documentation required)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a change in dosing?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i> <ul style="list-style-type: none"> • Patient continues to meet their individual goals of therapy for gender dysphoria • Patient continues to have a strong affinity for the desired (opposite of natal) gender • Discontinuation of treatment and subsequent pubertal development would interfere with or impair psychological functioning and well-being • Coexisting psychiatric and medical comorbidities or social problems that may interfere with treatment continue to be addressed or removed • Current enrollment, attendance, and active participation in psychological and social support treatment program • Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment • Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 	

Physician Signature: _____ **Date:** _____

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