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.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 ☐

UnitedHealthcare Community Plan

Gonadotropin-Releasing Hormone (GnRH) Agonists- New York EPP

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 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 - 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

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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Adjunct for gender-affirming hormonal therapy for transgender adults □ Advanced or metastatic prostate cancer □ Central precocious puberty (idiopathic or neurogenic) □ Endometriosis or endometriosis is suspected □ Fertility preservation □ Gender dysphoria in adolescents □ Infertility □ Uterine leiomyomata (fibroids)
ADJUNCT FOR GENDER-AFFIRMING HORMONAL THERAPY FOR TRANSGENDER ADULTS	
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax?** (*Documentation required)*
□ **Yes** □ **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?**
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy?**
□ **Yes** □ **No**	**Have the patient's gonads (i.e., testes, ovaries) been removed?**
□ **Yes** □ **No**	**Are the patient's gonads functional (e.g., hormone producing)?**
□ **Yes** □ **No**	**Is the patient currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender?**
□ **Yes** □ **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)?**
□ **Yes** □ **No**	**Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted?** *(If yes, please submit letter and/or documentation along with this fax)* • 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	
□ **Yes** □ **No**	**Did the onset of secondary sexual characteristics occur in the patient at one of the following ages?** *(If yes, check which applies)* □ ≤ 8 years of age in females □ ≤ 9 years of age in males
□ **Yes** □ **No**	**Was the diagnosis confirmed by any of the following?** *(If yes, check which applies)* □ A pubertal luteinizing hormone response to a GnRH stimulation test □ Bone age advanced one year beyond the chronological age □ Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)
□ **Yes** □ **No**	**For <u>Triptodur requests,</u> does the patient have a history of failure, contraindication, or intolerance to Lupron-Depot Ped?** *(If yes, complete Section D above)*
ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED *(Continued on next page)*	
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Non-steroidal anti-inflammatory drugs (NSAIDs) □ Oral contraceptives or depot medroxyprogesterone (e.g., Depo- Provera)
□ **Yes** □ **No**	**Has the patient had surgical ablation to prevent recurrence?**

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Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**For <u>Lupaneta Pack requests,</u> does the patient have a history of failure, contraindication, or intolerance to Lupron Depot?** *(If yes, complete Section D above)*
FERTILITY PRESERVATION	
□ Yes □ No	**Is the requested medication for use in a pre-menopausal woman?**
□ Yes □ 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	
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax?** (*Documentation required)*
□ Yes □ 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?**
□ Yes □ No	**Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy?**
□ Yes □ No	**Has the patient experienced puberty development to at least Tanner stage 2?**
□ Yes □ No	**Does the patient have laboratory tests, based upon the laboratory reference range, confirming any of the following?** *(If yes, check which applies)* □ A pubertal luteinizing hormone response to a GnRH stimulation test □ Pubertal basal level of luteinizing hormone (based on laboratory reference ranges) □ Pubertal levels of estradiol in females □ Pubertal levels of testosterone in males
□ Yes □ No	**Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted?** *(If yes, please submit letter and/or documentation along with this fax)* • 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)	
□ Yes □ No	**Is this request for the treatment of uterine leiomyomata-related anemia?**
□ Yes □ No	**Did the patient respond to 1 month of iron therapy?**
□ Yes □ No	**Will the requested medication be used prior to surgery?**
□ Yes □ 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 *(Continued on next page)*	
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax?** (*Documentation required)*
□ Yes □ No	**Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?**
□ Yes □ No	**Has the patient had a change in dosing?**
□ Yes □ No	**Are the patient's gonads (i.e., testes, ovaries) intact?**

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Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted?** *(If yes, please submit letter and/or documentation along with this fax)* • 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)	
□ Yes □ No	**Is the patient currently receiving therapy for central precocious puberty?**
□ Yes □ No	**Is there documentation of positive clinical response to therapy?**
CONTINUATION OF THERAPY - ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED	
□ Yes □ No	**Has the patient experienced a recurrence of symptoms following an initial course of therapy?**
□ Yes □ No	**Will the requested medication be used concurrently with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)?** *If yes, list add-back therapy:*
CONTINUATION OF THERAPY - FERTILITY PRESERVATION	
□ Yes □ No	**Is the patient currently receiving GnRH analog therapy for the purpose of fertility preservation?**
□ Yes □ 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	
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) demonstrating ALL of the following below be submitted along with this fax?** (*Documentation required)*
□ Yes □ No	**Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?**
□ Yes □ No	**Has the patient had a change in dosing?**
□ Yes □ No	**Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted?** *(If yes, please submit letter and/or documentation along with this fax)* • 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:** _____