

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 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**

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	<p>Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Atopic dermatitis <input type="checkbox"/> Chronic rhinosinusitis with nasal polyposis (CRSwNP) <input type="checkbox"/> Moderate-to-severe asthma
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is Dupixent prescribed by one of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Immunologist <input type="checkbox"/> Otolaryngologist <input type="checkbox"/> Pulmonologist
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ATOPIC DERMATITIS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does any of the following apply to the patient? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic atopic dermatitis that has been determined to be <u>moderate</u> in severity based on physician assessment <input type="checkbox"/> Chronic atopic dermatitis that has been determined to be <u>severe</u> based on physician assessment
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to any of the following topical therapies? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Medium to very-high potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)] <input type="checkbox"/> Topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)] <input type="checkbox"/> Eucrisa (crisaborole)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]?</p>
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CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient had any of the following symptoms for greater than or equal to 12 weeks duration? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Mucopurulent discharge <input type="checkbox"/> Nasal obstruction and congestion <input type="checkbox"/> Decreased or absent sense of smell <input type="checkbox"/> Facial pressure or pain
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have any of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Evidence of inflammation on paranasal sinus examination or computed tomography (CT) <input type="checkbox"/> Evidence of purulence coming from paranasal sinuses or ostiomeatal complex
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have nasal polyps?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient required any of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Prior sinonasal surgery <input type="checkbox"/> Systemic corticosteroids in the previous 2 years
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient been unable to obtain symptom relief after a trial of any of the following agents/classes? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Nasal saline irrigations <input type="checkbox"/> Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.) <input type="checkbox"/> Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will the patient receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids?</p>
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Member First name:		Member Last name:		Member DOB:	
MODERATE TO SEVERE ASTHMA					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20) <input type="checkbox"/> Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months <input type="checkbox"/> Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) <input type="checkbox"/> Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient currently dependent on oral corticosteroids for the treatment of asthma?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will Dupixent be used in combination with one high dose (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]? <i>If yes, list ICS/LABA product:</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will the patient use Dupixent with combination therapy including <u>both</u> of the following? <input type="checkbox"/> One high-dose (appropriately adjusted for age) inhaled corticosteroid (ICS) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] <input type="checkbox"/> One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline] <i>If yes, list combination therapy:</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level ≥ 150 cells/microliter within the past 6 weeks be submitted? <i>(DOCUMENTATION REQUIRED)</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will the patient receive Dupixent in combination with any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Anti-interleukin-5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasentra (benralizumab)] <input type="checkbox"/> Anti-IgE therapy [e.g. Xolair (omalizumab)]			
CONTINUATION OF THERAPY - ATOPIC DERMATITIS					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there documentation of positive clinical response to Dupixent therapy?			
CONTINUATION OF THERAPY - CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there documentation of positive clinical response to Dupixent therapy?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will the patient continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids?			
CONTINUATION OF THERAPY - MODERATE TO SEVERE ASTHMA					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there documentation of positive clinical response to Dupixent therapy as demonstrated by any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Reduction in the frequency of exacerbations <input type="checkbox"/> Decreased utilization of rescue medications <input type="checkbox"/> Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline <input type="checkbox"/> Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) <input type="checkbox"/> Reduction in oral corticosteroid requirements			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is Dupixent being used in combination with an inhaled corticosteroid (ICS)-containing controller medication?			

Physician Signature: _____ **Date:** _____

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