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 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 ☐

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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 - Physician 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 for a list of preferred alternatives

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (Check which applies)

□ Osteoporosis □ Glucocorticoid-Induced Osteoporosis

□ Other. **List diagnosis**: _____

- Does the patient have a history of one of the following resulting from minimal trauma: □ Yes □ No (check which applies)

□ Vertebral compression fracture □ Fracture of the hip

□ Fracture of the distal radius □ Fracture of the pelvis

□ Fracture of the proximal humerus

- Does the patient have a history of failure, contraindication, or intolerance to any of the following: □ Yes □ No

□ One conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator [SERM]

□ If the request is for a post-menopausal patient, history of failure, contraindication, or intolerance to Tymlos

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- List patient's BMD-T score: _____

(based on BMD measurements from lumber spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site))

- Has the patient previously received or is currently taking any parathyroid hormone analogs? □ Yes □ No

If yes, list how many months, in total, the patient has received of parathyroid hormone analogs: _____ months

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for OSTEOPOROSIS:

- Does the patient have one of the following FRAX 10-year probabilities: □ Yes □ No

□ Major osteoporotic fracture at 20% or more □ Hip fracture at 3% or more

Requests for GLUCOCORTICOID-INDUCED OSTEOPOROSIS:

- Does the patient have a history of prednisone or its equivalent at a dose ≥ 5mg/day for ≥ 3 months? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

☐ ***Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.***

Physician Signature: _____ Date: _____