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 ☐

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UnitedHealthcare Community Plan

Gonadotropin-Releasing Hormone Agonists

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 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	
☐ **Yes** ☐ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* ☐ Endometriosis ☐ Gender Dysphoria ☐ Advanced or metastatic prostate cancer ☐ Central Precocious Puberty (idiopathic or neurogenic) ☐ For treatment of anemia caused by uterine Leiomyomata (fibroids) ☐ For use prior to surgery to reduce the size of fibrosis to facilitate a surgical procedure
ELIGARD / TRELSTAR	
☐ **Yes** ☐ **No**	**Does the patient have a history of failure, contraindication, or intolerance to Lupron Depot (7.5mg, 22.5mg, 30mg, or 45mg) or Generic Leuprolide Acetate?** *(If yes, complete Section D above)*
ENDOMETRIOSIS	
☐ **Yes** ☐ **No**	**Does the patient have a history of inadequate pain control response following a trial of at least 6 months, or a history of intolerance or contraindication to any of the following?** *(If yes, check which applies and complete Section D above)* ☐ Danazol ☐ Combination (estrogen/progesterone) oral contraceptive ☐ Progestins
☐ **Yes** ☐ **No**	**Has the patient had surgical ablation to prevent recurrence?**
UTERINE LEIOMYOMATA (FIBROIDS) – ANEMIA	
☐ **Yes** ☐ **No**	**Has the patient tried and had an inadequate response to at least 1 month of monotherapy with iron?** *(If yes, complete Section D above)*
☐ **Yes** ☐ **No**	**Will this be used in combination with iron therapy prior to surgery?**
CENTRAL PRECOCIOUS PUBERTY	
☐ **Yes** ☐ **No**	**Is the medication prescribed by or in consultation with a pediatric endocrinologist?**
☐ **Yes** ☐ **No**	**Was there early onset of a secondary sexual characteristic at less than 8 or 9 years of age?** *(Check which apply)* ☐ Female: less than 8 years of age ☐ Male: less than 9 years of age ☐ Neither **List age of onset: ________________**
☐ **Yes** ☐ **No**	**Is there advanced bone age of at least one year compared with chronological age?**
☐ **Yes** ☐ **No**	**Has the patient undergone gonadotropin-releasing hormone agonist (GnRHa) testing?**
☐ **Yes** ☐ **No**	**Is the peak luteinizing hormone (LH) level above pre-pubertal range?**
☐ **Yes** ☐ **No**	**Does the patient have a random luteinizing hormone (LH) level in the pubertal range?**
☐ **Yes** ☐ **No**	**Are luteinizing hormone (LH) levels suppressed to pre-pubertal levels?**
☐ **Yes** ☐ **No**	**Has the patient had any diagnostic evaluations to rule tumors, when suspected?** (Check which applies) ☐ MRI or CT scan image of the brain, ☐ Pelvic/Testicular/Adrenal Ultrasound, ☐ Adrenal steroids to rule out congenital adrenal hyperplasia ☐ Patient has no suspected tumors
☐ **Yes** ☐ **No**	**Does the patient have a history of failure, contraindication, or intolerance to Lupron Depot-Ped?** *(If yes, complete Section D above)*

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Member First name:	Member Last name:	Member DOB:

CONTINUATION OF THERAPY	
□ Yes □ No	**Has there been recurrence of symptoms following a trial of at least 6 months with leuprolide acetate?** *(If yes, complete Section D above)*
□ Yes □ No	**Is the patient using Lupron Depot in combination with one of the following?** *(If yes, check which applies and complete Section D above)* □ Norethindrone 5mg daily □ Other "add-back" sex-hormones □ Other bone-sparing agents
□ Yes □ No	**Does the patient show evidence of progressive disease while on therapy?**

Physician Signature: ____ **Date:** ___________________

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