

**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](http://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 for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
---------------------------	--------------------------	--------------------

**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a diagnosis of hereditary angioedema (HAE) as confirmed by one of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene <input type="checkbox"/> A C4 level below the lower limit of normal and one of the following (per laboratory standard): C1 inhibitor (C1-INH) antigenic level below the lower limit of normal OR C1-INH functional level below the lower limit of normal
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will Haegarda be used for prophylaxis against HAE attacks?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will Haegarda be used in combination with other approved C1 esterase inhibitors indicated for prophylaxis against HAE attacks (e.g. Cinryze)?</b> <i>If yes, list medication and rationale:</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the prescriber attest that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Haegarda?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is Haegarda prescribed by one of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Immunologist <input type="checkbox"/> Allergist <input type="checkbox"/> Rheumatologist
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to Cinryze?</b> <i>(If yes, complete Section D above)</i>

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.