

## 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](http://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: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Sex:  Male  Female

### Provider Information

Provider's Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Suite Number: \_\_\_\_\_ Building Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

### Medication Information

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Refills: \_\_\_\_\_

**Physician Signature\*\*:** \_\_\_\_\_ **DAW (Initial here):** \_\_\_\_\_

**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 **NO** please provide the following:      Initiation Date: / /      Date of Last Dose: / /

**\*\*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



# INCRELEX

## PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:

### SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW**  or a **CONTINUATION of THERAPY** ? If so, start date: \_\_\_\_\_

Is this patient currently hospitalized?  Yes  No

### SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	
Office Contact Name / Fax Attention to:			

Medication to be Administered:  Physician's office  Patient's Home  Other

### SECTION C - MEDICAL INFORMATION

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	ICD-9 CODE:

What is the prescriber's specialty? \_\_\_\_\_

What is the patient's IGF-1 Level? \_\_\_\_\_

Does the patient have a height standard deviation score less than or equal to -3.0?  
(Circle Answer) YES or NO

Does the patient have normal or elevated growth hormone levels? (Circle Answer) YES or NO

Have epiphyses been confirmed open through wrist film evaluation?  
(Circle Answer) YES or NO

\*\*\* PLEASE FAX ALL APPROPRIATE SUPPORTING DOCUMENTATION WITH THIS REQUEST\*\*\*

1. Wrist film evaluation
2. Growth Chart/ Office Notes
3. Blood work (IGF-1, PROVOCATIVE TEST, ETC.)

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

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