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:

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 ☐

UnitedHealthcare Community Plan

LOVENOX

PRIOR AUTHORIZATION REQUEST FORM

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

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 #:	Specialty:	
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:

What is the patient's diagnosis? *(Check appropriate response and answer sub-questions)* **ICD-9 Code:** _____

- ☐ Acute ST-segment elevation myocardial infarction (STEMI)
- ☐ Unstable angina/non-Q-wave myocardial infarction (MI).
- ☐ Deep vein thrombosis (DVT) or Pulmonary Embolism (PE) – Not Pregnancy Related *(choose scenario below)*
  - ☐ Acute Treatment
    - ♦ Does this patient have cancer? Yes or No *(Circle answer)*
    - ♦ Is the requested medication being started along with warfarin (Coumadin), and then will be discontinued when the INR is in the therapeutic range? Yes or No *(Circle answer)*
      - If No, Please explain reason: _____
  - ☐ Long Term Treatment
  - ☐ Prevention of DVT or PE
    - ☐ Knee arthroplasty (replacement).
    - ☐ Hip arthroplasty (replacement)..
    - ☐ Status post surgery Type of surgery: _____
    - ☐ DVT or PE prevention in cancer patients.
    - ☐ DVT or PE prevention in patients with severely restricted mobility during acute illness. Provide Details: _____
    - ☐ Other: _____
- ☐ Treatment or prevention of thromboembolic disease or VTE (DVT or PE) during pregnancy,
  - ♦ Is member currently pregnant? Yes or No *(Circle Answer)* If yes what is patient's due date? _____ _
- ☐ Other. List diagnosis:_____
  - ♦ Is the requested medication being started along with warfarin (Coumadin), and then will be discontinued when the INR is in the therapeutic range? Yes or No *(Circle answer)*
    If No, Please explain reason: _____

If this is a request for a non-preferred low molecular weight heparin (Innohep, Arixtra, or Fragmin) please provide reason that preferred product (Lovenox) cannot be used: _____

Physician Signature: _____ **Date:** _____