UnitedHealthcare Community Plan

Specialty Medication Prior Authorization Cover Sheet

FAX BACK TO: (866) 940-7328 PHONE: (800) 310-6826

(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: / /

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 ☐

SPECIALTY PRODUCT REQUEST COVER SHEET

Lupron / Leuprolide

UnitedHealthcare Community Plan

PRIOR AUTHORIZATION REQUEST FORM

Complete BOTH PAGES of this 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 #:	Specialty:	
Office Contact Name / Fax Attention to:				

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

For requests for Endometriosis:

Does the patient have a history of failure, contraindication, or intolerance to both NASAIDS and Oral Contraceptives?

☐ YES ☐ NO If yes, please list medication names, dates of trial, and reason for discontinuing:

Medication	Dates of Therapy	Reason for Discontinuing

For Continuation of therapy: Have the patient's symptoms recurred after one course of leuprolide? ☐ YES ☐ NO

Will the requested medication be used in combination with one of the following?

☐ Norethindrone 5 mg daily

☐ Other "add-back" sex-hormones or other bone-sparing agents (Danazol, progesterone, oral contraceptives)

☐ None of the above

Lupron / Leuprolide

PRIOR AUTHORIZATION REQUEST FORM

For Prostate Cancer:

Does this patient have a diagnosis of prostate cancer? ☐ YES ☐ NO

For Continuation of therapy: Does the patient show evidence of progressive disease while on therapy? ☐ YES ☐ NO

For Uterine Leiomyomata (Fibroids):

Will leuprolide therapy be used for the reduction of the size of fibroids or for the treatment of anemia?

☐ Reduction of the size of fibroids ☐ Anemia

Will leuprolide be used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure? ☐ YES ☐ NO

Is this patient's anemia caused by uterine leiomyomata (fibroids)? ☐ YES ☐ NO

Did the patient respond to iron therapy that was at least 1 month in duration? ☐ YES ☐ NO

Will leuprolide be used prior to surgery? ☐ YES ☐ NO

For Central Precocious Puberty:

Female Patients: Did the patient have onset of sexual characteristics when less than 8 years of age? ☐ YES ☐ NO

Male Patients: Did the patient have onset of sexual characteristics when less than 9 years of age? ☐ YES ☐ NO

Was the patient's diagnosis defined by one of the following?

☐ A pubertal response to a GnRH stimulation test

☐ Bone age advanced one year beyond chronological age

☐ Other: (please specify) _____

For continuation of therapy: Must submit documentation of bone age monitoring for consideration of reauthorization.

Additional Clinical Information to support this request:

_____

_____

_____

Physician Signature: _____ Date: _____