

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

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

Select the patient's genotype: <input type="checkbox"/> Genotype 1 <input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3 <input type="checkbox"/> Genotype 4 <input type="checkbox"/> Genotype 5 <input type="checkbox"/> Genotype 6 <input type="checkbox"/> Other Genotype (Must Specify): _____	
Please select one of the following: <input type="checkbox"/> Compensated cirrhosis (Child-Pugh A) <input type="checkbox"/> Decompensated cirrhosis (Child-Pugh B or C) <input type="checkbox"/> No Cirrhosis	
Please select one of the following: <input type="checkbox"/> Patient is treatment naïve <input type="checkbox"/> Patient is treatment experienced	
Document the patient's weight: _____ Kg	
Duration of treatment: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other: _____ weeks	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used in combination with any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Peginterferon alfa <input type="checkbox"/> Ribavirin
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient ineligible for any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Peginterferon alfa <input type="checkbox"/> Ribavirin
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient received, or is in the process of receiving, full courses of both Hepatitis A and Hepatitis B vaccinations, or does the patient have immunity?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had genotyping results within 1 year before anticipated therapy start date?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by an infectious disease specialist, gastroenterologist, or hepatologist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by any primary care provider in consultation with an infectious disease specialist, gastroenterologist, or hepatologist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	For treatment naïve patients without cirrhosis, is the requested medication prescribed by any primary care provider who has completed the HCV ECHO (Extension for Community Healthcare Outcome) series (four, 1-hour trainings)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the physician attest to the patient's readiness for adherence [which may include assessment tools such as PREP-C (Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment)]?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the physician attest to the patient having Chronic HCV infection (presence of HCV RNA viral load for greater than or equal to 6 months to confirm infection is not acute or evidence that the infection has not spontaneously resolved)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	For women of childbearing potential, has a serum pregnancy testing been conducted within 30 days of expected direct-acting antiviral start date?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the provider be submitting ALL of the following laboratory tests within 6 months of initiating therapy? DOCUMENTATION REQUIRED <ul style="list-style-type: none"> CBC (complete blood count) Hepatic Function Panel [i.e. albumin, total and direct bilirubin, ALT (alanine aminotransferase), AST (aspartate aminotransferase), and alkaline phosphatase levels] Calculated GFR (glomerular filtration rate) If cirrhosis is present, calculation of the CTP (Child-Turcotte-Pugh) score Transplant status as applicable (pre-, post-, N/A)
<input type="checkbox"/> Yes <input type="checkbox"/> No	For treatments ≥ 12 weeks in duration, does the physician attest that if the week 4 HCV RNA is detectable (> 25 copies) while on therapy, HCV RNA will be reassessed in 2 weeks; and if the repeated HCV RNA level has not decreased [i.e. > 1 log₁₀ IU (international units)/mL from nadir], all treatment will be discontinued?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a life expectancy ≥ 12 month?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient's renal function greater than 30mL/min (including those requiring hemodialysis or peritoneal dialysis)?



Member First name:	Member Last name:	Member DOB:
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USE WITH RIBAVARIN-CONTAINING REGIMENS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient a pregnant female or a male with a pregnant female partner?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do women of childbearing potential and their male partners attest that they will use two forms of effective (non-hormonal) contraception during treatment?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient meet any of the following? <i>If yes, check which applies</i> <input type="checkbox"/> Known hypersensitivity to ribavirin <input type="checkbox"/> Autoimmune hepatitis <input type="checkbox"/> Hemoglobinopathies <input type="checkbox"/> Creatinine clearance < 50 mL/min (milliliters/minute) <input type="checkbox"/> Co-administered with didanosine

HARVONI (LEDIPASVIR/SOFOSBUVIR)

Document the patient's pre-treatment HCV RNA level: _____ million IU/mL

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient a liver transplant recipient?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a prior failure with Sovaldi (sofosbuvir)?

MAVYRET

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient treatment-experienced (previously treated) with any of the following? <i>(If yes, check all that apply)</i> <input type="checkbox"/> Daklinza <input type="checkbox"/> Peg-interferon <input type="checkbox"/> Harvoni <input type="checkbox"/> Ribavirin <input type="checkbox"/> Incivek <input type="checkbox"/> Sofosbuvir (Sovaldi) <input type="checkbox"/> Olysio <input type="checkbox"/> Victrelis
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SOVALDI

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax? <i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient awaiting a liver transplant or has liver carcinoma?

VOSEVI

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax? <i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient treatment experienced with a regimen containing sofosbuvir with or without an NS5A inhibitor (e.g., Daklinza, Viekira Pak, Harvoni, or Epclusa)?

ZEPATIER

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will documentation indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, patient has initiated treatment on a non-preferred drug and needs to complete therapy) be submitted along with this fax? <i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have baseline NS5A polymorphisms on amino acids 28/30/31/93?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient failed treatment with peg-interferon alfa and ribavirin?

Member First name:	Member Last name:	Member DOB:
RE-TREATMENT REQUESTS		
Document previous regimen medications and dates treated:		
Select the patient's genotype of previous HCV infection: <input type="checkbox"/> Genotype 1 <input type="checkbox"/> Genotype 2 <input type="checkbox"/> Genotype 3 <input type="checkbox"/> Genotype 4 <input type="checkbox"/> Genotype 5 <input type="checkbox"/> Genotype 6 <input type="checkbox"/> Other Genotype (Must Specify): _____		
Document any information regarding adherence to previously trialed regimen(s) and current chronic medications:		
Document adverse effects experienced from previous treatment regimen:		
Document concomitant therapies during previous treatment regimen:		

Provider Signature: _____ **Date:** _____

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