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: | ICD10 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

24 HOUR – URGENT

KUVAN

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 #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication to be administered: ☐ Physician Office ☐ Patient's Home ☐ Other

SECTION C - MEDICAL INFORMATION	
Medication:	
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is Kuvan being prescribed for the treatment of phenylketonuria (PKU)? *(circle answer)* **YES** or **NO**

For Reauthorization Requests Only:

Has the patient had a documented response to treatment as evidenced by a decrease in blood phenylalanine level? *(circle answer)* **YES** or **NO**

****Please include copies of phenylalanine labs with all requests****

****For Reauthorization please include initial and follow up phenylalanine labs****

Physician Signature: _____ Date: _____