

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: _____ 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: / /

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

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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-10 CODE:
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For requests for Endometriosis:

Does the patient have a history of failure, contraindication, or intolerance to both NSAIDS 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
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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: _____

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