

**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](http://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

## Hepatitis C Medications – New York PRIOR AUTHORIZATION REQUEST FORM

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:	Policy #:	Group #:

Is the requested medication  New or  Continuation of Therapy? If continuation, list start date: \_\_\_\_\_

Is this patient currently hospitalized?  Yes  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 *(This form is for Hepatitis C Medications only; for all other drugs please submit a new form)*

Medication 1:	Strength:
Directions for use:	Quantity:
Medication 2:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

Is this member pregnant?  Yes  No If yes, what is this member's due date? \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS WITH HEPATITIS C**  
All supporting labs and chart documentation is required for medical review of this request.

#### Genotype (Must submit supporting lab documentation)

Genotype 1     Genotype 2     Genotype 3     Genotype 4     Genotype 5     Genotype 6  
 Other Genotype (Must Specify): \_\_\_\_\_

Has the patient been treated for Hepatitis C previously?  Yes  No

If "Yes", please provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing: \_\_\_\_\_

### Section D – Previous Medication Trials

Trial	Regimen <i>(List all medications tried with each trial)</i>	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				
4				

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

**ALL REQUESTS**

**The following information below MUST be included upon submission:**

- Medication name, dose, and duration     Relevant medical records and laboratory results

**Please select one of the following:**

- Compensated cirrhosis (Child-Pugh A)     Decompensated cirrhosis (Child-Pugh B or C)     No Cirrhosis

**Document the patient's weight: \_\_\_\_\_ Kg**

**Duration of treatment:**     8 weeks     12 weeks     16 weeks     24 weeks     Other: \_\_\_\_\_ weeks

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the provider attest that they have assessed the patient's readiness to initiate hepatitis C virus (HCV) treatment, including drug and alcohol abuse potential?</b>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Liver transplant recipient <input type="checkbox"/> Kidney transplant recipient
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will the requested medication used in combination with any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Peginterferon alfa <input type="checkbox"/> Ribavirin
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient ineligible for any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Interferon <input type="checkbox"/> Ribavirin
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**EPCLUSA**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If request is for <u>brand</u> Eplclusa, is there an explanation of medical necessity for brand versus the authorized generic?</b> <i>If yes, provide explanation:</i>
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**HARVONI OR LEDIPASVIR/SOFOSBUVIR (AUTHORIZED GENERIC OF HARVONI)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of intolerance or contraindication to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Mavyret <input type="checkbox"/> Sofosbuvir/velpatasvir (the authorized generic of Eplclusa) <input type="checkbox"/> Zepatier
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient treatment-experienced (previously treated) with any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Peginterferon alfa + ribavirin based regimen with or without an HCV protease inhibitor <input type="checkbox"/> Interferon based regimen with or without ribavirin
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If request is for <u>brand</u> Harvoni, is there an explanation of medical necessity for brand versus the authorized generic?</b> <i>If yes, provide explanation:</i>
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**MAVYRET**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient treatment-experienced (previously treated) with any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> An NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor <input type="checkbox"/> An NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor <input type="checkbox"/> Interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor <input type="checkbox"/> Other (please specify): _____
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## Hepatitis C Medications – New York PRIOR AUTHORIZATION REQUEST FORM

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<b>SOVALDI</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of intolerance or contraindication to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mavyret</li> <li><input type="checkbox"/> Sofosbuvir/velpatasvir (the authorized generic of Epclusa)</li> <li><input type="checkbox"/> Zepatier</li> </ul>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient treatment-experienced (previously treated) with an interferon based regimen with or without ribavirin?</b>	
<b>VOSEVI</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of intolerance or contraindication to Mavyret?</b> <i>(If yes, complete Section D above)</i>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has the patient been previously treated with a NS3/4A inhibitor?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does any of the following apply to the patient?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor.</li> <li><input type="checkbox"/> Genotype 2, 3, 4, 5, or 6, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor.</li> <li><input type="checkbox"/> Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir <u>without</u> an NS5A inhibitor.</li> <li><input type="checkbox"/> Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir <u>without</u> an NS5A inhibitor.</li> <li><input type="checkbox"/> Other (please specify): _____</li> </ul>	
<b>ZEPATIER</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have baseline NS5A polymorphisms?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient treatment-experienced (previously treated) with any of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Peginterferon alfa + ribavirin</li> <li><input type="checkbox"/> Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor</li> </ul>	

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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