

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.uhprovider.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

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Moderate to severe chronic plaque psoriasis <input type="checkbox"/> Moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III) <input type="checkbox"/> Moderately to severely active Crohn’s disease <input type="checkbox"/> Moderately to severely active polyarticular juvenile idiopathic arthritis <input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA) <input type="checkbox"/> Moderately to severely active ulcerative colitis <input type="checkbox"/> Non-infectious uveitis (UV)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will the patient receive Humira in combination with any of the following? <i>(if yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Biologic DMARD [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab)] <input type="checkbox"/> Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)] <input type="checkbox"/> Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have history of failure to a 3-month trial of methotrexate at up to the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i></p>
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ANKYLOSING SPONDYLITIS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure to two NSAIDs (non-steroidal anti-inflammatory drugs) [e.g., ibuprofen, naproxen] at up to maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i></p>
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CROHN’S DISEASE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure to any of the following conventional therapies at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> 6-mercaptopurine (Purinethol) <input type="checkbox"/> Azathioprine (Imuran) <input type="checkbox"/> Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) <input type="checkbox"/> Methotrexate (Rheumatrex, Trexall)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient lost response or is intolerant to infliximab (e.g., Remicade, Inflectra, Renflexis)? <i>(If yes, complete Section D above)</i></p>
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HIDRADENITIS SUPPURATIVA

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure to at least one oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i></p>
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PLAQUE PSORIASIS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have greater than or equal to 5% body surface area (BSA) involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have history of failure to any of the following topical therapies within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anthralin <input type="checkbox"/> Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) <input type="checkbox"/> Coal tar <input type="checkbox"/> Corticosteroids (e.g., betamethasone, clobetasol, desonide) <input type="checkbox"/> Tazarotene <input type="checkbox"/> Vitamin D analogs (e.g., calcitriol, calcipotriene)
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Member First name:		Member Last name:		Member DOB:	
RHEUMATOID ARTHRITIS (RA)					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure to a 3 month trial of any non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at up to maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i>			
ULCERATIVE COLITIS					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure to any of the following conventional therapies at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, check which applies and complete Section D above)</i>			
		<input type="checkbox"/> 6-mercaptopurine (Purinethol) <input type="checkbox"/> Azathioprine (Imuran) <input type="checkbox"/> Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) <input type="checkbox"/> Methotrexate (Rheumatrex, Trexall)			
UVEITIS (UV)					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient's diagnosis classified as any of the following? <i>(If yes, check which applies)</i>			
		<input type="checkbox"/> Intermediate <input type="checkbox"/> Panuveitis <input type="checkbox"/> Posterior			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure to at least one corticosteroid (e.g., prednisolone, prednisone) at up to a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure to at least one systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at up to a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced? <i>(If yes, complete Section D above)</i>			
CONTINUATION OF THERAPY					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a documented positive clinical response to Humira therapy? <i>If yes, list response:</i>			

Physician Signature: _____ **Date:** _____

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