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.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 ☐

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UnitedHealthcare Community Plan

Hepatitis C Medications - Pennsylvania
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): _____

Prescriber Specialty: **□ Hepatologist** **□ Gastroenterologist** **□ Infectious Disease Specialist**
□ Transplant Physician **□ Other (Specify):**

Has this 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 (*List all medications tried with each trial)*	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				
4				

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

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
	Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other: _____ weeks
□ **Yes** □ **No**	**Does the patient have a diagnosis of chronic hepatitis C?**
□ **Yes** □ **No**	**Does the patient weigh at least 35 kg?**
□ **Yes** □ **No**	**Is the patient any of the following?** *(If yes, check which applies)* □ Liver transplant recipient □ Kidney transplant recipient
□ **Yes** □ **No**	**Is there documentation of any of the following?** *(If yes, check which applies)* □ A complete hepatitis B immunization series □ Hepatitis B screening (sAb/sAg and cAb)
□ **Yes** □ **No**	**Is the patient negative for hepatitis BsAb?**
□ **Yes** □ **No**	**Does the patient have a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series?**
□ **Yes** □ **No**	**Is the patient positive for hepatitis BsAg?**
□ **Yes** □ **No**	**Was a quantitative HBV (hepatitis B virus) DNA done?** □ Yes, and there is detectable HBV DNA □ Yes, and there is NO detectable HBV DNA
□ **Yes** □ **No**	**Will the patient have a treatment plan for hepatitis B consistent with AASLD (American Association for the Study of Liver Diseases) recommendations?**
□ **Yes** □ **No**	**Does the patient have a documented HIV screening (HIV Ag/Ab)?**
□ **Yes** □ **No**	**If the patient has a confirmed positive by HIV-1/HIV-2 differentiation immunoassay, are any of the following true?** *(If yes, check which applies)* □ Patient is being treated for HIV □ Patient is not being treated for HIV and the medical record documents the rationale for not being treated *List rationale:*
□ **Yes** □ **No**	**Does the patient have documentation of AASLD-recommended resistance-associated substitution (RAS) testing?**
□ **Yes** □ **No**	**Has the patient had a previous treatment failure with a direct-acting antiretroviral (DAA) and the regimen prescribed is an AASLD recommended drug regimen based on the documented results of a NS5A RAS screening?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient actively abusing alcohol or IV (intravenous) drugs, or has a history of abuse?**
□ **Yes** □ **No**	**Is there documentation of prescriber counseling regarding the risks of alcohol or IV drug abuse and an offer of a referral for substance use disorder treatment?**
□ **Yes** □ **No**	**Is the patient's Metavir fibrosis score documented by a recent noninvasive test such as a blood test or imaging, a FibroScan, or findings on physical examination?**
□ **Yes** □ **No**	**Does the patient have a life expectancy of less than 12 months due to non-liver-related comorbid conditions?**
□ **Yes** □ **No**	**Does the patient have documented quantitative HCV (hepatitis C virus) RNA (ribonucleic acid) at baseline that was tested within the past 3 months?**
□ **Yes** □ **No**	**If the patient has a history of failed treatment due to non-adherence, were the causes of non-adherence to a previously prescribed hepatitis C treatment regimen corrected or addressed?**
□ **Yes** □ **No**	**Has the patient had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the patient of the risks associated with the use of both medications when they interact)?**
□ **Yes** □ **No**	**Will the requested medication be taken with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Is the patient ineligible for any of the following?** *(If yes, check which applies)* □ Interferon □ Ribavirin
□ Yes □ No	**Does the patient have a pretreatment hemoglobin of at least 10 g/dL (grams per deciliter)?**
□ Yes □ No	**If the patient is female, does any of the following apply to the patient?** *(If yes, check which applies)* □ Patient had a negative pregnancy test immediately prior to initiating therapy □ Patient will be using two or more forms of contraception □ Patient will have monthly pregnancy tests during therapy
□ Yes □ No	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred hepatitis C agents appropriate for the patient's genotype according to peer-reviewed medical literature?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a documented commitment to adherence with the planned course of treatment and mutual prescriber and departmental monitoring?**
	EPCLUSA
□ Yes □ No	**Has the patient failed a peginterferon alfa + ribavirin based regimen with or without an HCV protease inhibitor?**
	HARVONI
□ Yes □ No	**Is the patient treatment-experienced with interferon based regimen with or without ribavirin?**
	MAVYRET
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies and complete Section D above)* □ An NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor □ An NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor □ Interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor □ Other (please specify): _____
	SOVALDI
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with interferon based regimen with or without ribavirin?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first?**
	VOSEVI
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies and complete Section D above)* □ An NS5A inhibitor □ Sofosbuvir without an NS5A inhibitor
	ZEPATIER
□ Yes □ No	**Does the patient have baseline NS5A polymorphisms?**
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa + ribavirin □ Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor
	RETREATMENT REQUESTS
□ Yes □ No	**Are services medically necessary to meet the medical needs of the patient?**

Physician Signature: _____ **Date:** _____

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