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 ☐

UnitedHealthcare Community Plan

Hepatitis C Medications – Pennsylvania CHIP Only
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 (*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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Hepatitis C Medications – Pennsylvania CHIP Only
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

Document the patient's weight: _____ Kg

Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other: _____ weeks

□ **Yes** □ **No**	**Is the requested medication being prescribed one of the following?** *(If yes, check which applies)* □ Gastroenterologist □ Infectious disease specialist □ Hepatologist □ Transplant physician □ HIV specialist certified through the American Academy of HIV medicine
□ **Yes** □ **No**	**Does the physician/provider assert that the patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen?**
□ **Yes** □ **No**	**Is the patient any of the following?** *(If yes, check which applies)* □ Kidney transplant recipient □ Liver transplant recipient
□ **Yes** □ **No**	**Will the requested medication used in combination with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin
□ **Yes** □ **No**	**Is the patient ineligible for any of the following?** *(If yes, check which applies)* □ Interferon □ Ribavirin

EPCLUSA

□ **Yes** □ **No**	**If request is for <u>brand</u> Epclusa, is there an explanation of medical necessity for brand versus the authorized generic?** *If yes, provide explanation:*

HARVONI OR LEDIPASVIR/SOFOSBUVIR (AUTHORIZED GENERIC OF HARVONI)

Document the patient's pre-treatment HCV RNA level _____ million IU/mL

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

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

	MAVYRET
□ **Yes** □ **No**	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies)* □ 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**	**Does the patient have a history of intolerance or contraindication to any of the following?** *(If yes, check which applies and complete Section D above)* □ Mavyret □ Sofosbuvir/velpatasvir (the authorized generic of Epclusa) □ Zepatier
□ **Yes** □ **No**	**Does the patient have hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first?**
□ **Yes** □ **No**	**Is the patient treatment-experienced (previously treated) with an interferon based regimen with or without ribavirin?**
	VOSEVI
□ **Yes** □ **No**	**Does the patient have a history of intolerance or contraindication to Mavyret?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Has the patient been previously treated with a NS3/4A inhibitor?**
□ **Yes** □ **No**	**Does any of the following apply to the patient?** *(If yes, check which applies)* □ Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor. □ 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. □ Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor. □ Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor. □ Other (please specify): _____
	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

Physician Signature: _____ **Date:** _____