

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**: Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and		y pharmacy with a prescription	
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions	d/or coordination of delivery for t	y pharmacy with a prescription he requested medication.	
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Selection	d/or coordination of delivery for t	y pharmacy with a prescription he requested medication.	
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sel Is this medication a New Start?	d/or coordination of delivery for t	y pharmacy with a prescription he requested medication. Yes No Yes No	
Physician Signature**: By signing above, the part that can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sel Is this medication a New Start? If continuation please provide the following:	d/or coordination of delivery for to delivery for the del	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / /	
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sells this medication a New Start? If continuation please provide the following: Is there documentation of positive clinical recommendation.	d/or coordination of delivery for to delivery for the del	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / /	
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sells this medication a New Start? If continuation please provide the following: Is there documentation of positive clinical reference attach any pertinent clinical informational clinical information may be need previously tried and failed.	d/or coordination of delivery for the de	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / / Yes No No No Description)
Physician Signature**: By signing above, the partner can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sell Is this medication a New Start? If continuation please provide the following: Is there documentation of positive clinical reference attach any pertinent clinical inform Additional clinical information may be need.	d/or coordination of delivery for the de	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / / Yes No No No Description)
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Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Sells this medication a New Start? If continuation please provide the following: Is there documentation of positive clinical reference attach any pertinent clinical inform Additional clinical information may be need previously tried and failed. Delivery Instructions Note: Delivery coordination requires a "Physical reprovider Information" and "Patient Information" and	If-Administer? Initiation Date: / / esponse to current therapy? mation that would pertain to suded depending on your patient ician Signature" above and control information a	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / / Yes No Ipport stated diagnosis. Is plan, including medication(s) Inplete In the time of delivery)
Physician Signature**: By signing above, the pathat can be used to facilitate the dispensing and Medication Instructions Has the patient been instructed on how to Select Is this medication a New Start? If continuation please provide the following: Is there documentation of positive clinical recommendational clinical information may be need previously tried and failed. Delivery Instructions Note: Delivery coordination requires a "Physical Provider Information" and "Patient Information" and "Patient Information" and "Patient Information" and "Patient Information" supplies are provided in the provider information of positive clinical recommendation in the pathatest information in the pathatest informa	If-Administer? Initiation Date: / / esponse to current therapy? mation that would pertain to suded depending on your patient ician Signature" above and control information a	y pharmacy with a prescription he requested medication. Yes No Yes No Date of Last Dose: / / Yes No Ipport stated diagnosis. Is plan, including medication(s) Inplete In the time of delivery)



Hepatitis C Medications – Pennsylvania CHIP Only PRIOR AUTHORIZATION REQUEST FORM

Please complete this <u>entire</u> 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	n A – Member Information					
First Na	me:	Last Name:		1	Member ID:	
Address:						
City:		State:			ZIP Code:	
Phone:		DOB:		,	Allergies:	
Primary	Insurance:	Policy #:		(Group #:	
	equested medication □ New or □ C					
Is this	patient currently hospitalized?	Yes □ No	If recently discharg	ged, list discha	rge date:	
Sectio	n B - Provider Information					
First Na	ame:		Last Name:			M.D./D.O.
Addres	S:		City:	;	State:	ZIP code:
Phone:	Fax:		NPI #:	;	Specialty:	
Office (Contact Name / Fax attention to:					
	n C - Medical Information (<i>This forn</i>	n is for Hep	atitis C Medications or	nly; for all other		bmit a new form)
Medica	ation 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:					E:	
Is this	member pregnant? Yes No	If yes	s, what is this membe	er's due date?		
	THIS SECTION MUST All supporting labs and cha					west
Gonoty	pe (Must submit supporting lab do			or medical rev	lew or this req	uest.
-		Genotype	-	□ Genoty	me 5 □ G	Senotype 6
□ 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						
outco	ome of treatment / reason for disco	ontinuing:				
	on D – Previous Medication Trials					
Trial	Regimen (List all medications t each trial)	ried with	Dates of Therapy	Treatment Complete		of Treatment or Discontinuation
1	,			•		
2						
3						
4						



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Member Firs	t name:	Member Last name:	Member DOB:			
Clinical and Drug Specific Information						
		ALL REQUESTS				
□ M (nformation below <u>MUST</u> be included upduration Relevant medical records and				
	lect one of the following: sated cirrhosis (Child-Pugh	A) □ Decompensated cirrhosis (Child-Pu	gh B or C) □ No Cirrhosis			
Documen	t the patient's weight:	Kg				
Duration of	of treatment: 8 weeks	\Box 12 weeks \Box 16 weeks \Box 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					
	l	EPCLUSA				
□ Yes □ No	If request is for <u>brand</u> Ep authorized generic? If yes, provide explanation	clusa, is there an explanation of medica	al necessity for brand versus the			
HARVONI OR LEDIPASVIR/SOFOSBUVIR (AUTHORIZED GENERIC OF HARVONI)						
Documen	t the patient's pre-treatme	nt HCV RNA level million IU/m	L			
□ Yes □ No	(If yes, check which applie ☐ Mavyret	nistory of intolerance or contraindication is and complete Section D above) (the authorized generic of Epclusa)	n to any of the following?			
□ 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 brand Ha authorized generic? If yes, provide explanation	rvoni, is there an explanation of medica	I necessity for brand versus the			



error, please notify the sender immediately.

Hepatitis C Medications – Pennsylvania CHIP Only PRIOR AUTHORIZATION REQUEST FORM

Date: _____

Mer	nber First name:	Member Last name:	Member DOB:		
MAVYRET					
□ Yes □ No	(If yes, check which applie □ An NS5A inhibitor witho □ An NS3/4A protease inh	experienced (previously treated) with any s) ut prior treatment with an NS3/4A protease hibitor without prior treatment with an NS5A erferon, ribavirin, and/or sofosbuvir, but no for or NS5A inhibitor	e inhibitor a inhibitor		
		SOVALDI			
□ Yes □ No	(If yes, check which applie □ Mavyret	nistory of intolerance or contraindication is and complete Section D above) the authorized generic of Epclusa)	n to any of the following?		
□ Yes □ No	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 pre-	viously 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	·	seline NS5A polymorphisms?			
□ Yes □ No	(If yes, check which applied □ Peginterferon alfa + riba	,	y of the following?		

Physician Signature: _____ Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in