

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

Hepatitis C Medications – Rhode Island 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 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 <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 with current medication list
 Laboratory results dated within the last 90 days Agreement to submit post-treatment viral load data if requested

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

Document the patient's quantitative viral load and date of testing (date of testing must be within 90 days of request:

Quantitative viral load: _____ Date of testing: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a continuation of treatment when transitioning between publicly funded delivery systems (e.g., between fee for service Medicaid and managed care Medicaid, between managed care Medicaid and fee for service Medicaid, or between the department of corrections and the Medicaid program)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have documented chronic hepatitis C, stage 0 through 4, including the test used to determine disease stage? <i>If yes, list disease stage and test used to determine disease stage:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient managed by a provider on the Rhode Island Medicaid Hepatitis C Preferred Provider List who either assumes direct responsibility for care or who, after consultation and establishing a treatment plan, co-manages the patient with the primary care provider?
<input type="checkbox"/> Yes <input type="checkbox"/> No	For patients with decompensated cirrhosis, was the patient referred to a physician with experience in managing such disease (ideally at a center with liver transplant capabilities)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient any of the following? (If yes, check which applies) <input type="checkbox"/> Liver transplant recipient <input type="checkbox"/> Kidney transplant recipient

MAVYRET

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following? (If yes, check which applies) <input type="checkbox"/> Genotype 1, 2, 3, 4, 5, or 6 and treatment naïve <input type="checkbox"/> Genotype 1 and treatment-experienced (previously treated) with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor <input type="checkbox"/> Genotype 1 and treatment-experienced (previously treated) with an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor <input type="checkbox"/> Genotype 1, 2, 3, 4, 5, or 6 and treatment-experienced (previously treated) with interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor
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VOSEVI

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the any of the following apply to the patient? (If yes, check which applies) <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 <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 <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 <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
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been previously treated with an NS3/4A inhibitor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of intolerance or contraindication to Mavyret? <i>(If yes, complete Section D above)</i>

**Hepatitis C Medications – Rhode Island
PRIOR AUTHORIZATION REQUEST FORM**

Member First name:	Member Last name:	Member DOB:
NON-PREFERRED AGENTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient completing a cycle therapy which was initiated prior to current policy implementation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there detailed clinical documentation of the need for an alternative, non-preferred agent? <i>If yes, provide documentation:</i>	

Physician Signature: _____ **Date:** _____

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