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.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: | Date of Birth: | Height: | Weight:

Address: | Apartment #:

City: | State: | Zip:

Phone Number: | Alternate Phone: | Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: | Provider ID Number:

Address: | City: | State: | Zip:

Suite Number: | Building Number:

Phone Number: | Fax number:

Provider's Specialty:

Medication Information

Medication: | Quantity: | ICD-10 Code:

Directions: | Diagnosis: | Refills:

Physician Signature**: | DAW (Initial here):

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 **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****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

Leukine, Neupogen, Neulasta

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE**

For what indication is the medication being requested for? (Check Appropriate Response)

- □ Bone marrow/stem cell transplant
- □ Neutropenia associated with cancer chemotherapy
- □ Hepatitis-C treatment related neutropenia
- □ Myelodysplastic syndrome related neutropenia
- □ (AML) following induction or consolidation chemotherapy
- □ Severe chronic neutropenia
- □ HIV-related neutropenia
- □ Other _____

For Bone marrow/stem cell transplant, will the patient be undergoing any of the following

- □ Myeloablative chemotherapy followed by autologous or allogenic bone marrow transplant
- □ Mobilitzation of hematopoietic progenitor cells into the peripheral blood for leukapheresis
- □ Peripheral stem cell transplant (PSCT) with myeloablative chemotherapy
- □ Other _____

Is the patient currently receiving chemotherapy? Yes or No (Circle Answer)
If yes, please list chemotherapy regimen _____
If yes, Which of the following categories will the requested medication be used for?

- □ Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN)
- □ Secondary prophylaxis of febrile neutropenia
- □ Treatment of febrile neutropenia
- □ Other _____

Did the patient have a history of febrile neutropenia during a previous course of chemotherapy? Yes or No (Circle Answer)
Does the patient have any risk factors for experiencing febrile neutropenia? Yes or No (Circle Answer)
If yes, List risk factors: _____

If this is to be used in conjunction with an erythropoiesis stimulating agent, what is the patient's current serum erythropoietin level?
List EPO level : _____ mU/ml Date of Result: _____

If the patient is being treated for severe chronic neutropenia, HIV related neutropenia or Hep C related neutropenia,what is the patient's current ANC? ANC _____cells/mm^3 Date of Result:_____

If the patient is being treated for Myelodysplastic syndrome related neutropenia: Does the patient have neutropenia and has had recurrent or resistant infections? Yes or No (Circle Answer)

Physician Signature: _____ **Date:** _____