

**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](http://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

**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 Information:

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**

Medication:	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? \_\_\_\_\_

**Section D – Previous Medication Trials**

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?</b> <i>(If yes, please submit medical records (e.g., chart notes, laboratory values))</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient currently on Ilumya therapy?</b> <i>If yes, list start date:</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have greater than or equal to 5% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis?</b> <i>(If yes, please submit medical records (e.g., chart notes, laboratory values))</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to any of the following topical therapies?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Corticosteroids (e.g., betamethasone, clobetasol, desonide) <input type="checkbox"/> Vitamin D analogs (e.g., calcitriol, calcipotriene) <input type="checkbox"/> Tazarotene <input type="checkbox"/> Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) <input type="checkbox"/> Anthralin <input type="checkbox"/> Coal tar
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance of a 3 month trial of methotrexate?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of failure, contraindication, or intolerance to any of the following preferred biologic products?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Enbrel (etanercept) <input type="checkbox"/> Cimzia (certolizumab)
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there submission of medical records (e.g., chart notes, laboratory values) documenting a history of a 6 month trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there submission of medical records (e.g., chart notes, laboratory values) documenting a history of intolerance or adverse event to Cosentyx?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there submission of medical records (e.g., chart notes, laboratory values) documenting the physician attests, that in their clinical opinion, the same intolerance or adverse event would not be expected to occur with Ilumya?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Will the patient receive Ilumya in combination with any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)] <input type="checkbox"/> Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)] <input type="checkbox"/> Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

**CONTINUATION OF THERAPY**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a documented positive clinical response to Ilumya therapy?</b> <i>If yes, list response:</i>
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**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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