

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

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Member First name:	Member Last name:	Member DOB:
Clinical and Drug Specific Information		
ALL REQUESTS		
List pre-treatment LDL-C: _____ mg/dL	List treated LDL-C: _____ mg/dL	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient have Xanthoma before 10 years of age?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Juxtapid be used as an adjunct to a low-fat diet and exercise?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)? <i>If yes, list other lipid-lowering therapy:</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of intolerance, failure or contraindication to Repatha (evolocumab)? <i>(If yes complete Section D above)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Juxtapid be used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Juxtapid be used in combination with Kynamro (mipomersen)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Juxtapid prescribed by any of the following? (If yes, check which applies) <input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Lipid specialist	
CONTINUATION OF THERAPY		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient continuing a low-fat diet and exercise regimen?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient continue to receive other lipid-lowering therapy (e.g., statin, LDL apheresis)? <i>If yes, list other lipid-lowering therapy:</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented LDL-C reduction while on Juxtapid therapy as confirmed by submission of medical records (e.g., chart notes, laboratory values)?	

Physician Signature: _____ **Date:** _____

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