UnitedHealthcare Community Plan

Lynparza
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 may contain 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 (if any):		

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

Medication Name	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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis?
□ Epithelial Ovarian Cancer □ Fallopian Tube Cancer □ Primary Peritoneal Cancer
□ Other. List diagnosis: _____

- Did the patient have a complete or partial response to platinum-based chemotherapy? □ Yes □ No
(If yes, complete Section D above with medication information, date of trial, and reason for discontinuation)

- Is the disease one of the following? □ Yes □ No
□ Advanced □ Persistent □ Recurrent

- Does the patient have the presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test? □ Yes □ No

- Does the patient have history of failure, contraindication, or intolerance to three or more prior lines of chemotherapy (e.g., paclitaxel with cisplatin)? □ Yes □ No
(If yes, complete Section D above with medication information, date of trial, and reason for discontinuation)

- Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? □ Yes □ No
If yes, list supported use: _____

Requests for BREAST CANCER:

- Is the disease one of the following: □ Yes □ No (check which applies)
□ Metastatic □ Recurrent

- Is the disease human epidermal growth factor receptor 2 (HER2)-negative? □ Yes □ No

- Is the disease hormone receptor (HR) positive? □ Yes □ No

- Has the disease progressed on previous endocrine therapy? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the provider attest that treatment with endocrine therapy is inappropriate for the patient's disease?
□ Yes □ No

Requests for CONTINUATION OF CARE:

- Does the patient show evidence of progressive disease while on Lynparza therapy? □ Yes □ No

- Does the patient have a documented positive clinical response to Lynparza therapy? □ Yes □ No
If yes, list response: _____
_____

Provider Signature: _____ **Date:** _____