UnitedHealthcare Community Plan

Hematopoietic Agents Erythropoiesis Stimulating Agents – Washington

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 at www.uhcprovider.com 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

□ Yes □ No	**Does the patient have any of the following diagnoses?** *(If yes, check all that apply)* □ Anemia Due to Chronic Kidney Disease (CKD) □ Anemia of prematurity □ Anemia Associated with Zidovudine-Treated HIV-Infected Patients □ Anemia of Cancer Patients on Chemotherapy, where the intent of treatment is palliative □ Anemia Associated with Myelodysplastic Syndrome to Reduce Transfusion Dependency □ Anemia After Allogeneic Bone Marrow Transplantation □ Anemia due to Ribavirin in Patients who did not experience an improvement in Hemoglobin level with Ribavirin dose reduction □ To reduce the need for blood transfusions in anemic participants scheduled to undergo high-risk surgery who are at increased risk or intolerant to transfusions □ Special circumstance patients who will not or cannot receive whole blood or components as replacement for traumatic or surgical loss
List patient's most recent hemoglobin level: g/dL	
□ Yes □ No	**Did the patient have an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least two preferred agents?** *(If yes, complete Section D above)*

ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD)

□ Yes □ No	**Is there documentation of adequate iron stores as indicated by current (within the last 3 months) serum ferritin level greater than or equal to 100 mcg/L or serum transferrin saturation greater than or equal to 20%?** *If yes, list serum ferritin and/or serum transferrin:*

ANEMIA OF PREMATURITY

□ Yes □ No	**Is there documentation of refusal of transfusion due to religious or cultural reasons?**

CONTINUATION OF THERAPY

□ Yes □ No	**Is there documentation of positive clinical response (e.g., as evidenced by decrease in blood transfusions) submitted by the prescriber?**
□ Yes □ No	**Is there documentation of positive clinical response submitted by the prescriber?**

Provider Signature: _____ **Date:** _____