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.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 ☐

UnitedHealthcare Community Plan

Hematopoietic Agents-Granulocyte Colony Stimulating Factors- 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 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 at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Hematopoietic Agents-Granulocyte Colony Stimulating Factors- Washington

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does any of the following apply to the patient?** *(If yes, check which applies)* □ Receiving induction and/or consolidation chemotherapy for acute myeloid leukemia (AML) □ Primary prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy □ Secondary prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy □ Treatment of febrile neutropenia □ Diagnosis of cancer and undergoing bone marrow transplantation □ Undergoing autologous peripheral blood progenitor cell collection and therapy □ Severe chronic neutropenia □ Hematopoietic sub syndrome of acute radiation syndrome
□ Yes □ No	**Does 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)*
PRIMARY PREVENTION OF FEBRILE NEUTROPENIA	
□ Yes □ No	**Does the chemotherapy regimen have a greater than 20 percent risk for febrile neutropenia?**
□ Yes □ No	**Does the chemotherapy regimen have a 10 to 20 percent risk for febrile neutropenia?**
□ Yes □ No	**Does the patient meet any of the following?** *(If yes, check which applies)* □ Extensive prior chemotherapy or radiation therapy to pelvis or other areas important for bone marrow reserve □ Persistent neutropenia (ANC 1000/mm^3 or less) □ Bone marrow involvement by tumor □ Recent surgery and/or open wounds □ Liver dysfunction (bilirubin > 2.0 mg/dL) □ Renal dysfunction (eGFR < 50 mL/min/1.73m^2) □ Age > 65 years and receiving full chemotherapy dose intensity □ Poor performance status
□ Yes □ No	**Has the patient experienced treatment delay of curative chemotherapy due to a dose-limiting neutropenic event, with the same dose and schedule planned for future cycles?**
□ Yes □ No	**Is there documentation of treatment failure or a clearly stated rational of an inability to complete course of treatment (e.g. patient is unable to administer daily injections, patient is a young child, etc.) with a preferred short-acting G-CSF?** *(If yes, complete Section D above)*
SECONDARY PREVENTION OF FEBRILE NEUTROPENIA	
□ Yes □ No	**Has the patient experienced febrile neutropenia with a previous cycle of similar chemotherapy, with the same dose and schedule planned for future cycles?**
□ Yes □ No	**Has the patient experienced treatment delay of curative chemotherapy due to a dose-limiting neutropenic event, with the same dose and schedule planned for future cycles?**
□ Yes □ No	**Has the patient experienced treatment delay of palliative chemotherapy due to a dose-limiting neutropenic event, and dose reduction or a delay in frequency of subsequent chemotherapy cycles is not recommended?**
□ Yes □ No	**Is there documentation of treatment failure or a clearly stated rational of an inability to complete course of treatment (e.g. patient is unable to administer daily injections, patient is a young child, etc.) with a preferred short-acting G-CSF?** *(If yes, complete Section D above)*

UnitedHealthcare Community Plan

Hematopoietic Agents-Granulocyte Colony Stimulating Factors- Washington

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

TREATMENT OF FEBRILE NEUTROPENIA	
□ **Yes** □ **No**	**Does the patient have one any of the following high-risk factors?** *(If yes, check which applies)* □ Age greater than 65 years □ Hospitalized for febrile neutropenia □ Sepsis syndrome □ Invasive fungal infection □ Clinically documented infection such as pneumonia □ Prolonged or profound neutropenia □ History of prior episodes of febrile neutropenia
WITH CANCER UNDERGOING BONE MARROW TRANSPLANTATION	
□ **Yes** □ **No**	**Is Filgrastim administered at least 24 hours after any of the following?** *(If yes, check which applies)* □ Cytotoxic chemotherapy □ Bone marrow infusion
□ **Yes** □ **No**	**Are CBC & platelet counts monitored daily during neutrophil recovery?**
UNDERGOING AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL COLLECTION AND THERAPY	
□ **Yes** □ **No**	**Is Filgrastim administered for at least 4 days before the first leukapheresis procedure?**
□ **Yes** □ **No**	**Is Filgrastim continued until the last leukapheresis?**
SEVERE CHRONIC NEUTROPENIA (SCN)	
□ **Yes** □ **No**	**Has the diagnosis been confirmed by evaluating serial CBCs with differential and platelet counts, and evaluating bone marrow morphology and karyotype?**
ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION	
□ **Yes** □ **No**	**Has the patient been exposed to lethal doses of total-body radiation, but not doses high enough to lead to certain death as a result of injury to other organs?**

Physician Signature: _____ **Date:** _____