

**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

## Hematopoietic Agents Thrombopoiesis Stimulating Proteins – 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 <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: Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives

## Hematopoietic Agents Thrombopoiesis Stimulating Proteins – Washington PRIOR AUTHORIZATION REQUEST FORM

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<b>Clinical and Drug Specific Information</b>		
<b>ALL REQUESTS</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have any of the following diagnoses?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Chronic immune thrombocytopenic purpura (ITP) <input type="checkbox"/> Aplastic anemia <input type="checkbox"/> Chronic hepatitis C-associated thrombocytopenia <input type="checkbox"/> Thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure	
<b>CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of platelet count of less than <math>30 \times 10^9/L</math> (<math>30,000/mm^3</math>)?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have history of failure, contraindication, or intolerance to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Immunoglobulins <input type="checkbox"/> Rituximab <input type="checkbox"/> Previous history of splenectomy	
<b>APLASTIC ANEMIA</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have history of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy which includes but is not limited to the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Antithymocyte globulin equine (Atgam) <input type="checkbox"/> Antithymocyte globulin rabbit (Thymoglobulin) <input type="checkbox"/> Cyclosporine	
<b>CHRONIC HEPATITIS C-ASSOCIATED THROMBOCYTOPENIA</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is thrombocytopenia preventing the initiation of interferon-based therapy or limiting the ability to maintain an interferon-based therapy?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have any of the following:</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> A reason why the patient cannot use direct acting antivirals for hepatitis C <input type="checkbox"/> Planning to initiate and maintain interferon-based treatment <input type="checkbox"/> Currently receiving interferon-based treatment	
<b>CONTINUATION OF THERAPY</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of positive clinical response (e.g., increase in platelet count)?</b>	
<b>CONTINUATION OF THERAPY- PROMACTA – CHRONIC HEPATITIS C WITH THROMBOCYTOPENIA</b>		
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient currently on interferon-based therapy for treatment of chronic hepatitis C?</b>	
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of positive clinical response (e.g., increase in platelet count)?</b>	

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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