

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 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**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Chronic myelogenous/myeloid leukemia (CML) <input type="checkbox"/> Philadelphia chromosome positive acute lymphoblastic leukemia (Ph +ALL)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there confirmed documentation of T315I mutation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unable to take, or has failed treatment with, two or more tyrosine kinase inhibitor (TKI) therapies [e.g., imatinib mesylate, Sprycel (dasatinib), or Tasigna (nilotinib)]? <i>(If yes, complete section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Iclusig being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? <i>If yes, list supported use:</i>

PHILADELPHIA CHROMOSOME (PH +ALL)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Iclusig be used in combination with an induction regimen not previously used? <i>If yes, list regimen:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Iclusig be used as a component of Hyper-CVAD (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone, alternating with high-dose methotrexate and cytarabine) induction or consolidation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Iclusig be used as maintenance therapy in combination with vincristine and prednisone with or without methotrexate and mercaptopurine? <i>(If yes, complete section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Iclusig be used as maintenance therapy post-hematopoietic stem cell transplant?

CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient show evidence of progressive disease while on Iclusig therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented positive clinical response to Iclusig therapy? <i>If yes, list response:</i>

Physician Signature: _____ **Date:** _____

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