

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 <u>www.uhcprovider.com</u> 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 C	ode:			
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	1:			
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 Dos	e: / /			
Is there documentation of positive clinical res	sponse 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 <u>and</u> complete "Provider Information" <u>and</u> "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 Add	Iress 🔲 Date medication is r	needed: / /				
Medication Administered: Home Health Self-Administered LTC Physician's Office						

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Idhifa - 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 Inform	nation	1						
First Name:		Last Nam	e:		Memb	per 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 ho	spitalized?	Yes 🗆 No	o If recently disch	arged, list disch	arge	date:		
Section B - Provider Inform	nation							
First Name:			Last Name:				M.D./D.O.	
Address:	•		City:		State		ZIP code:	
Phone:	Fax:		NPI #:		Spec	ialty:		
Office Contact Name / Fax a	attention to:							
Section C - Medical Inform Medication:	nation				St	rength:		
Directions for use:								
Directions for use:					Q	uantity:		
Diagnosis (Please be speci	fic & provide as	much info	rmation as possible	e):	IC	D-10 COD	E:	
Is this member program 2		If you	what is this mon	nhor's due date?	`			
Is this member pregnant?		lf yes	s, what is this men	nber's due date?	?			
Is this member pregnant? Section D – Previous Medi Medications	cation Trials	If yes	s, what is this men Directions	nber's due date? Dates of The			on for failure /	
Section D – Previous Medi	cation Trials						on for failure / ontinuation	
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Idhifa - Washington



PRIOR AUTHORIZATION REQUEST FORM

Member Firs	t name:	Member Last name:	Member DOB:				
Clinical and Drug Specific Information							
ALL REQUESTS							
🗆 Yes 🗆 No	Does the patient have a diagnosis of acute myeloid leukemia (AML)?						
	Is Idhifa being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?						
	• If yes, list supported use:						
ACUTE MYELOID LEUKEMIA (AML)							
🗆 Yes 🗆 No	Is the patient IDH2 mutation-positive?						
🗆 Yes 🗆 No	Does the patient have relapsed or refractory AML?						
🗆 Yes 🗆 No	Is the patient a candidate for intensive induction therapy?						
🗆 Yes 🗆 No	Will Idhifa be used for post remission therapy following response to low intensity induction therapy?						
CONTINUATION OF THERAPY							
🗆 Yes 🗆 No	Does the patient show evidence of progressive disease while on Idhifa therapy?						
	Does the patient have a	documented positive clinical response	to Idhifa therapy?				
🗆 Yes 🗆 No	Yes D No If yes, list response:						

Physician Signature: _____

Date: _____

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