

Intron A and Sylatron - 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: <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

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

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	<p>Does the patient have any of the following?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Hepatitis B Infection <input type="checkbox"/> Myeloproliferative Neoplasms (MPNs) [such as essential thrombocythemia (ET), polycythemia vera (PV), or primary myelofibrosis (PM)] <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Condylomata Acuminata (genital or perianal) <input type="checkbox"/> AIDS-Related Kaposi's Sarcoma <input type="checkbox"/> Leptomeningeal Metastases <input type="checkbox"/> Meningiomas <input type="checkbox"/> Kidney Cancer <input type="checkbox"/> Follicular Lymphoma <input type="checkbox"/> Adult T-Cell Leukemia / Lymphoma <input type="checkbox"/> Mycosis Fungoides / Sézary Syndrome <input type="checkbox"/> Desmoid Tumors / Aggressive Fibromatosis <input type="checkbox"/> Giant Cell Tumor of the Bone <input type="checkbox"/> Malignant Melanoma <input type="checkbox"/> Systemic mastocytosis
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TREATMENT OF HEPATITIS B

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient <u>without</u> decompensated liver disease?</p>
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Provider Signature: _____ **Date:** _____

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