

## **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 Co	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	:			
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	e: / /			
Is there documentation of positive clinical res	ponse 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						
<ul> <li>Note: Delivery coordination requires a "Physician Signature" above <u>and</u> complete "Provider Information" <u>and</u> "Patient Information"</li> <li>Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery</li> </ul>						
Ship to: Physician's Office 🗌 Patient's Add	ress 🔲 Date medication is r	needed: / /				
Medication Administered: Home Health 🗌 Self-Administered 🔲 LTC 🔲 Physician's Office 🗌						
This electronic fax transmission, including any attachments contains inform	ation for or from UnitedHealthcare that may be c	onfidential and/or privileged. T	he information contained			

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## Korlym - 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 Informa	ation						
First Name:		Last Name	:		Member ID:		
Address:							
City:		State:			ZIP Code:		
Phone:		DOB:			Allergies:		
Primary Insurance Information:							
Is the requested medication		ontinuatio	on of Therapy? If	continuation, lis	t start	date:	
Is this patient currently hos	pitalized? 🗆 `	Yes 🗆 No	If recently discha	arged, list disch	arge o	late:	
Section B - Provider Inform	ation						
First Name:			Last Name:				M.D./D.O.
Address:			City:		State	:	ZIP code:
Phone:	Fax:		NPI #:		Speci	alty:	
Office Contact Name / Fax at	tention to:						
Section C - Medical Informa	tion						
Medication:					St	rength:	
Directions for use:					Qı	antity:	
Diagnosis (Please be specifi	c & provide as	much infor	mation as possible	e):	IC	D-10 COD	DE:
Is this member pregnant?		lf ves	, what is this men	nher's due date?	<u> </u>		
Section D – Previous Medic		n 900,					
Medications	Strei	ngth	Directions	Dates of Therapy Reason for failure /			
						disc	ontinuation
Section E – Additional inforn	nation and Ex	planation of	of why preferred r	nedications wou	uld no	t meet the	e patient's needs:
PI	ease refer to	the patient	's PDL for a list o	f preferred alter	native	S	

Korlym - Washington

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:		Member Last name:	Member DOB:			
Clinical and Drug Specific Information						
		ALL REQUESTS				
🗆 Yes 🗆 No	□ No Does the patient have a diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)?					
□ Yes □ No	<ul> <li>Does the patient have ONE of the following diagnoses? (If yes, check which applies)</li> <li>Type 2 diabetes mellitus</li> <li>Glucose intolerance</li> </ul>					
□ Yes □ No	•	rgery OR is not a candidate for surgery? a patient is not a candidate for surgery:				
CONTINUATION OF THERAPY						
□ Yes □ No	No       Does the patient have documentation of ONE of the following? (If yes, check which applies)         □       Patient has improved glucose tolerance while on Korlym therapy         □       Patient has stable glucose tolerance while on Korlym therapy					

## Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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