

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.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID:	Date of Birth:	Height:	Weight:
Address:	Apartment #:		
City:	State:	Zip:	
Phone Number:	Alternate Phone:	Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female

Provider Information

Provider's Name:	Provider ID Number:
Address:	City: State: Zip:
Suite Number:	Building Number:
Phone Number:	Fax number:

Provider's Specialty: _____

Medication Information

Medication:	Quantity:	ICD10 Code:
Directions:	Diagnosis:	Refills:

Physician Signature**: _____ DAW (Initial here): _____

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 **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****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

Leukine, Neupogen, Neulasta

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name: M.D./D.O.	
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
SECTION C - MEDICAL INFORMATION			
Medication:		Strength:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE
For what indication is the medication being requested for? (Check Appropriate Response)			
<input type="checkbox"/> Bone marrow/stem cell transplant		<input type="checkbox"/> (AML) following induction or consolidation chemotherapy	
<input type="checkbox"/> Neutropenia associated with cancer chemotherapy		<input type="checkbox"/> Severe chronic neutropenia	
<input type="checkbox"/> Hepatitis-C treatment related neutropenia		<input type="checkbox"/> HIV-related neutropenia	
<input type="checkbox"/> Myelodysplastic syndrome related neutropenia		<input type="checkbox"/> Other _____	
For Bone marrow/stem cell transplant, will the patient be undergoing any of the following			
<input type="checkbox"/> Myeloablative chemotherapy followed by autologous or allogenic bone marrow transplant		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Mobilization of hematopoietic progenitor cells into the peripheral blood for leukapheresis			
<input type="checkbox"/> Peripheral stem cell transplant (PSCT) with myeloablative chemotherapy			
Is the patient currently receiving chemotherapy? Yes or No (Circle Answer)			
If yes, please list chemotherapy regimen _____			
If yes, Which of the following categories will the requested medication be used for?			
<input type="checkbox"/> Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN)			
<input type="checkbox"/> Secondary prophylaxis of febrile neutropenia			
<input type="checkbox"/> Treatment of febrile neutropenia			
<input type="checkbox"/> Other _____			
Did the patient have a history of febrile neutropenia during a previous course of chemotherapy? Yes or No (Circle Answer)			
Does the patient have any risk factors for experiencing febrile neutropenia? Yes or No (Circle Answer)			
If yes, List risk factors: _____			
If this is to be used in conjunction with an erythropoiesis stimulating agent, what is the patient's current serum erythropoietin level?			
List EPO level : _____ mU/ml Date of Result: _____			
If the patient is being treated for severe chronic neutropenia, HIV related neutropenia or Hep C related neutropenia, what is the patient's current ANC? ANC _____ cells/mm ³ Date of Result: _____			
If the patient is being treated for Myelodysplastic syndrome related neutropenia: Does the patient have neutropenia and has had recurrent or resistant infections? Yes or No (Circle Answer)			

Physician Signature: _____ **Date:** _____

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