

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

ORAL CHEMOTHERAPY PRIOR AUTHORIZATION REQUEST

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

SECTION A - PATIENT INFORMATION			
First Name:	Last Name:	Member ID:	
Address:			
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:		
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
SECTION C - MEDICAL INFORMATION			
Medication:	Strength:	Frequency of Dosage:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE:
Is the requested agent being used as first line therapy? Yes or No (circle Answer)			
If No, please fill out the following table (Please include both Oral and IV therapies):			
Previous Medication Regimens:			
Drug Name, Strength, and Directions for Use	Dates of Therapy	Reason for Discontinuing Therapy	
Will the requested product be used alone or in combination with another agent? _____			
If being used as part of combination therapy please list chemotherapy regimen: _____			

Affinitor Requests:			
Is the patient's condition unresectable, locally advanced, or metastatic? Yes or No (Circle answer)			
Hycamtin Requests: (Circle answer)			
Has at least 45 days passed since the end of the patient's treatment with first line chemotherapy? Yes or No			
Temodar Requests:			
Temodar be used with radiotherapy? Yes_ or_ No_ (Circle answer)			
Tykerb Requests:			
Is the Patient post-menopausal? Yes or No (Circle Answer)			
Xeloda or Gleevec Requests:			
Has the patient undergone complete resection of the primary tumor? Yes_ No_ (Circle answer)			
If this is a request for reauthorization, has this patient benefited from current therapy? Yes or No (Circle answer)			
Additional clinical information to support this request:			

Physician Signature: _____ Date: _____

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