UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

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.uhcprovider.com 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 Code:

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: / /

Is there documentation of positive clinical response 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 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 ☐

UnitedHealthcare Community Plan

Monoclonal Antibodies – Anti-IL, Anti-IgE - Pennsylvania

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 Information

First Name:	Last Name:	Member 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 hospitalized? □ Yes □ 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? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	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

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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**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Asthma □ Chronic idiopathic urticaria
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.,)?**
□ **Yes** □ **No**	**Has the patient received appropriate vaccinations as recommended in the FDA-approved package labeling unless contraindicated?**
□ **Yes** □ **No**	**Will the patient be evaluated, treated, and/or monitored for parasitic (helminth) infection before and/or during treatment with the prescribed monoclonal antibody (MAB) – anti-interleukin (IL), anti-immunoglobulin E (IgE) as recommended in FDA-approved package labeling?**
□ **Yes** □ **No**	**Will the requested medication be used in combination with another MAB – anti-IL, anti-IgE?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, intolerance, or contraindication of the preferred MAB – anti-IL, anti-IgE approved or medically accepted for the beneficiary's indication?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred MAB – anti-IL, anti-IgE?**
	ASTHMA
□ **Yes** □ **No**	**Does the patient have an asthma severity that is consistent with the FDA-approved indication for the prescribed MAB – anti-IL, anti-IgE despite maximal therapeutic doses of or intolerance or contraindication to asthma controller medications based on current national treatment guidelines for the diagnosis and management of asthma?**
□ **Yes** □ **No**	**Will the patient use the requested MAB – anti-IL, anti-IgE in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma?**
□ **Yes** □ **No**	**Does the patient have asthma with an eosinophilic phenotype?**
□ **Yes** □ **No**	**Does the patient have one of the following?** *(If yes, check which applies)* □ Absolute blood eosinophil count greater than or equal to 150 cells/microliter □ Absolute blood eosinophil count greater than or equal to 400 cells/microliter
□ **Yes** □ **No**	**For Xolair (omalizumab), does any of the following apply?** *(If yes, check which applies)* □ Has a diagnosis of allergen-induced asthma (allergic asthma confirmed by either a positive skin test or radioallergosorbent test) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.) □ Has a serum total IgE measurement between 30 International Units/milliliter and 1300 International Units/milliliter
	CHRONIC IDIOPATHIC URTICARIA
□ **Yes** □ **No**	**Does the patient have a documented history of urticaria for a period of at least 3 months?**
□ **Yes** □ **No**	**Does the patient require steroids to control urticarial symptoms?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses of any of the following?** *(If yes, check which applies and complete Section D above)* □ Histamine 1 (H1) antihistamine □ Histamine 2 (H2) antihistamine □ Leukotriene modifier □ Dapsone, sulfasalazine, or hydroxychloroquine
	CONTINUATION OF THERAPY – ASTHMA (cont'd on the next page)
□ **Yes** □ **No**	**Is the patient being monitored and treated, if applicable, for parasitic (helminth) infection as recommended in the Food and Drug Administration (FDA)-approved package labeling?**

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Monoclonal Antibodies – Anti-IL, Anti-IgE - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Does the patient have documented measurable evidence of improvement in the severity of the asthma condition?**
□ Yes □ No	**Does the patient continue to use the requested MAB – Anti-IL, Anti-IgE in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma?**
CONTINUATION OF THERAPY - CHRONIC IDIOPATHIC URTICARIA	
□ Yes □ No	**Is the patient being monitored and treated, if applicable, for parasitic (helminth) infection as recommended in the Food and Drug Administration (FDA)-approved package labeling?**
□ Yes □ No	**Does the patient have documentation of any of the following?** *(If yes, check which applies)* □ Improvement of symptoms □ Rationale for continued use

Physician Signature: _____ **Date:** _____