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.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: ☐ Male ☐ 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: ICD-10 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 ☐

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Leukine, Neupogen, Neulasta
PRIOR AUTHORIZATION REQUEST FORM

UnitedHealthcare Community Plan

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

Today's Date

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 ☐ or a CONTINUATION of THERAPY☐? If so, start date:__________________

Is this patient currently hospitalized? ☐Yes ☐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)

- ☐ Bone marrow/stem cell transplant
- ☐ Neutropenia associated with cancer chemotherapy
- ☐ Hepatitis-C treatment related neutropenia
- ☐ Myelodysplastic syndrome related neutropenia
- ☐ (AML) following induction or consolidation chemotherapy
- ☐ Severe chronic neutropenia
- ☐ HIV-related neutropenia
- ☐ Other ________________________________

For Bone marrow/stem cell transplant, will the patient be undergoing any of the following

- ☐ Myeloablative chemotherapy followed by autologous or allogenic bone marrow transplant
- ☐ Mobilitzation of hematopoietic progenitor cells into the peripheral blood for leukapheresis
- ☐ Peripheral stem cell transplant (PSCT) with myeloablative chemotherapy
- ☐ Other ________________________________

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?

- ☐ Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN)
- ☐ Secondary prophylaxis of febrile neutropenia
- ☐ Treatment of febrile neutropenia
- ☐ 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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