

## 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](http://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

# Leukine, Neupogen, Neulasta

## PRIOR AUTHORIZATION REQUEST FORM

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

<b>Today's Date</b>			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name: M.D./D.O.	
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
<b>Medication:</b>		<b>Strength:</b>	
<b>Directions for use:</b>			
<b>Diagnosis</b> (Please be specific & provide as much information as possible):			<b>ICD-10 CODE</b>

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<sup>3</sup> 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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