

**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](http://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

**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 for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Renal Cell Carcinoma (RCC)</li> <li><input type="checkbox"/> Hepatocellular Carcinoma</li> <li><input type="checkbox"/> Follicular Carcinoma</li> <li><input type="checkbox"/> Hürthle Cell Carcinoma</li> <li><input type="checkbox"/> Papillary Carcinoma</li> <li><input type="checkbox"/> Medullary Thyroid Carcinoma</li> <li><input type="checkbox"/> Angiosarcoma</li> <li><input type="checkbox"/> Desmoid Tumors / Aggressive Fibromatosis</li> <li><input type="checkbox"/> Progressive Gastrointestinal Stromal Tumors (GIST)</li> <li><input type="checkbox"/> Solitary Fibrous Tumor / Hemangiopericytoma</li> <li><input type="checkbox"/> Chordoma</li> <li><input type="checkbox"/> Osteosarcoma</li> <li><input type="checkbox"/> Dedifferentiated Chondrosarcoma</li> <li><input type="checkbox"/> High-Grade Undifferentiated Pleomorphic Sarcoma (UPS)</li> <li><input type="checkbox"/> Acute Myeloid Leukemia (AML)</li> </ul>
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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Is Nexavar requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?</b></p> <p><i>If yes, list supported use:</i></p>
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**RENAL CELL CARCINOMA (RCC)**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has the patient's disease relapsed?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a medically or surgically unresectable tumor?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a diagnosis of Stage IV disease?</b>

**HEPATOCELLULAR CARCINOMA**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have metastatic disease?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have extensive liver tumor burden?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient a transplant candidate?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the disease unresectable?</b>

**THYROID CANCER**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have any of the following?</b> <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unresectable recurrent disease</li> <li><input type="checkbox"/> Persistent locoregional disease</li> <li><input type="checkbox"/> Metastatic disease</li> <li><input type="checkbox"/> Progressive disease</li> <li><input type="checkbox"/> Disease is symptomatic with distant metastases</li> </ul>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have symptomatic or progressive disease?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the disease refractory to radioactive iodine treatment?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have a history of failure, contraindication, or intolerance to any of the following?</b></p> <p><i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Caprelsa (vandetanib)</li> <li><input type="checkbox"/> Cometriq (cabozantinib)</li> </ul>

<b>Member First name:</b>		<b>Member Last name:</b>		<b>Member DOB:</b>	
<b>SOFT TISSUE SARCOMA</b>					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Does the patient have a history of failure, contraindication, or intolerance to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i>			
		<input type="checkbox"/> Gleevec (imatinib) <input type="checkbox"/> Sutent (sunitinib) <input type="checkbox"/> Stivarga (regorafenib)			
<b>BONE CANCER</b>					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Is the disease recurrent?</b>			
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Will Nexavar be used as first-line therapy?</b> <i>(If no, list previous therapy in Section D above)</i>			
<b>ACUTE MYELOID LEUKEMIA</b>					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Does the patient have FLT3-ITD mutation-positive disease?</b>			
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Does the patient have relapsed or refractory disease?</b>			
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Will Nexavar be used in combination with any of the following?</b> <i>(If yes, check which applies)</i>			
		<input type="checkbox"/> Vidaza (azacitidine) <input type="checkbox"/> Dacogen (decitabine)			
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Is the patient unable to tolerate more aggressive treatment regimens?</b>			
<b>CONTINUATION OF THERAPY</b>					
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Does the patient show evidence of progressive disease while on Nexavar therapy?</b>			
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>		<b>Does the patient have a documented positive clinical response to Nexavar therapy?</b> <i>If yes, list positive response:</i>			

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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