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

Non-Preferred Hepatitis C Medications - Virginia
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:	Policy #:	Group #:

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 ***(This form is for Hepatitis C Medications only; for all other drugs please submit a new form)***

Medication 1:	**Strength:**
Directions for use (Include length of therapy):	**Quantity:**
Medication 2:	**Strength:**
Directions for use (Include length of therapy):	**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? _____

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS WITH HEPATITIS C
All supporting labs and chart documentation is required for medical review of this request.

Genotype (Must submit supporting lab documentation)
□ Genotype 1 □ Genotype 2 □ Genotype 3 □ Genotype 4 □ Genotype 5 □ Genotype 6
□ Other Genotype (Must Specify): _____

Section D – Previous Medication Trials

Trial	Regimen (*List all medications tried with each trial)*	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				
4				

UnitedHealthcare Community Plan

Non-Preferred Hepatitis C Medications - Virginia
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Has the provider assessed the patient to indicate if they meet the following diagnoses (provider must document what diagnoses the patient meets)?** *(If yes, check which applies)* □ Chronic hepatitis C □ Hepatocellular carcinoma □ Compensated cirrhosis □ Decompensated cirrhosis □ Status post liver transplant
□ **Yes** □ **No**	**Has the patient been evaluated for severe renal impairment (eGFR < 30 ml/min/1.73m^2) and end stage renal disease (ESRD) requiring hemodialysis?** *If yes, list results:*
□ **Yes** □ **No**	**Is the requested medication or regimen being prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist or transplant specialist?** *If yes, list specialty:*
□ **Yes** □ **No**	**Does the patient have decompensated cirrhosis (Child-Pugh score greater than 6 [class B or C])?**
□ **Yes** □ **No**	**Has the provider reviewed the patient readiness criteria below?** • Patient compliance to treatment regimen • Patient does not have Hepatitis B • Patient is not pregnant, breastfeeding or planning to breastfeed • Patient is not taking atazanavir or rifampin • Patient does not have severe kidney problems or is not on dialysis • Patient does not have HIV • Patient does not have severe liver cirrhosis or a Child-Push score class B or C
□ **Yes** □ **No**	**Has there been a therapeutic failure with the preferred drug within the same class [MAVYRET and/or sofosbuvir-velpatasvir (authorized generic of Epclusa)], or is there any reason the patient cannot be changed to the preferred drug within the same class (such as allergy, contraindication, or history of side effects)?** *(If yes, complete Section D above or list reason[s] below)* *List reason(s):*
PEGASYS	
□ **Yes** □ **No**	**Has there been a therapeutic failure with the preferred drug within the same class (PegIntron), or is there any reason the patient cannot be changed to the preferred drug within the same class (such as allergy, contraindication, or history of side effects)?** *(If yes, complete Section D above or list reason[s] below)* *List reason(s):*

Physician Signature: _____ **Date:** _____