

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

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**

| | | |
|---------------------------|--------------------------|--------------------|
| Member First name: | Member Last name: | Member DOB: |
|---------------------------|--------------------------|--------------------|

Clinical and Drug Specific Information

ALL REQUESTS

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Moderately to severely active Crohn's disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Is the patient receiving Stelara in combination with any of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)] <input type="checkbox"/> Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)] <input type="checkbox"/> Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)] |
| <p>List patient's weight: _____ kg</p> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Is there submission of medical records (e.g. chart notes, laboratory values, prescription claims history) documenting a history of failure, contraindication, or intolerance to any of the following preferred biological products? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Humira (adalimumab) <input type="checkbox"/> Enbrel (etanercept) |

PLAQUE PSORIASIS

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Is there submission of medical records (e.g. chart notes, laboratory values, prescription claims history) documenting greater than or equal to 5% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis?</p> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Is there submission of medical records (e.g. chart notes, laboratory values, prescription claims history) documenting a history of failure, contraindication, or intolerance to one of the following topical therapies? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Corticosteroids (e.g., betamethasone, clobetasol, desonide) <input type="checkbox"/> Vitamin D analogs (e.g., calcitriol, calcipotriene) <input type="checkbox"/> Tazarotene <input type="checkbox"/> Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) <input type="checkbox"/> Anthralin <input type="checkbox"/> Coal tar |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Is there submission of medical records (e.g. chart notes, laboratory values, prescription claims history) documenting a history of contraindication, intolerance, or failure of a 3 month trial of methotrexate? <i>(If yes, complete Section D above)</i></p> |

CONTINUATION OF THERAPY

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>Does the patient have a documented positive clinical response to Stelara therapy?</p> <p><i>If yes, list response:</i></p> |
|--|--|

Physician Signature: _____ **Date:** _____

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