UnitedHealthcare Community Plan

URGENT – 24 Hours

SIGNIFOR

PRIOR AUTHORIZATION REQUEST FORM

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

SECTION A - PATIENT INFORMATION		
Today's Date:	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:				

Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD 10 Code:**

SECTION C – CLINICAL INFORMATION

Initial Requests:

Does this patient have a diagnosis of endogenous Cushing's disease? *(Circle Response)*
YES or NO

Did this patient undergo pituitary surgery that was not curative for the patient? *(Circle Response)*
YES or NO

Is this patient a candidate for pituitary surgery? *(Circle Response)* YES or NO

Is the prescriber an endocrinologist? *(Circle Response)* YES or NO

Re-Authorization Requests:

Has this patient demonstrated a positive clinical response to Signifor therapy? (Circle Response)
YES or NO
Please describe benefit of therapy: _____

_____

_____

Physician Signature: _____ **Date:** _____

UnitedHealthcare®
Community Plan

Physician Signature: _____ **Date:** _____

Phone: 800-310-6826 Fax: 866-940-7328 Website: www.uhccommunityplan.com