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 ☐

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Repatha

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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

□ Yes □ No	**Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.**
	*****Verification of labs and/or other medical records must be submitted*****
	ALL REQUESTS
	List pre-treatment LDL-C values: _____ mg per dL Date: _____ *(Required)* **List most recent treated LDL-C values: _____ mg per dL Date: _____ *(Required)***
□ Yes □ No	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Heterozygous Familial Hypercholesterolemia (HeFH) □ Atherosclerotic Cardiovascular Disease (ASCVD) □ Homozygous Familial Hypercholesterolemia (HoFH)
□ Yes □ No	**Will Repatha be used as an adjunct to a low-fat diet and exercise?**
□ Yes □ No	**Is Repatha prescribed by any of the following:** *(If yes, check which applies)* □ Cardiologist □ Endocrinologist □ Lipid Specialist
□ Yes □ No	**Will Repatha be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?** *If yes, list drug:*
	HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH):
□ Yes □ No	**Has the patient's diagnosis been confirmed by medical records documenting the patient had xanthoma before 10 years of age?**
□ Yes □ No	**Has the patient's diagnosis been confirmed by medical records documenting evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents?**
□ Yes □ No	**Is the patient receiving other lipid-lowering therapy (e.g., statin, Zetia [ezetimibe], LDL apheresis)?** *If yes, list other lipid-lowering therapy:*
□ Yes □ No	**Will Repatha be used in combination with Juxtapid (lomitapide)?**
	HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH)
□ Yes □ No	**Does the patient meet <u>any</u> of the following:** *(If yes, check all that apply)* □ Family history of myocardial infarction in first-degree relative < 60 years of age □ Family history of myocardial infarction in second-degree relative <50 years of age □ Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative □ Family history of familial hypercholesterolemia in first- or second-degree relative □ Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative
□ Yes □ No	**Has the patient's diagnosis been confirmed by medical records documenting any of the following:** *(f yes, check which applies)* □ Functional mutation in LDL, apoB, or PCSK9 gene □ Tendinous xanthomata □ Arcus cornealis before age 45
	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)
□ Yes □ No	**Has the patient's diagnosis been confirmed by any of the following:** *(If yes, check all that apply)* □ Acute coronary syndromes □ History of myocardial infarction □ Stable or unstable angina □ Stroke □ Transient ischemic attack □ Coronary or other arterial revascularization □ Peripheral arterial disease presumed to be of the atherosclerotic origin
	HeFH and ASCVD
□ Yes □ No	**Does the patient have a labeled contraindication to all statins as documented in medical records?**
□ Yes □ No	**Has the physician provided medical records documenting the patient has been receiving at least 12 consecutive weeks of a <u>high-intensity statin therapy</u> and will continue to receive high-intensity statin at the maximally tolerated dose?** *(If yes, complete Section D above)*

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Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Has the physician provided medical records documenting the patient is unable to tolerate high-intensity statins as evidenced by one of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:** □ Myalgia (muscle symptoms without CK elevations) □ Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])
□ Yes □ No	**Has the physician provided medical records documenting the patient has been receiving at least 12 consecutive weeks of a moderate-intensity statin and will continue to receive a moderate-intensity statin at the maximally tolerated dose?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the physician provided medical records documenting the patient has been receiving at least 12 consecutive weeks of low-intensity statin therapy and will continue to receive a low-intensity statin at maximally tolerated dose?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the physician provided medical records documenting the patient is unable to tolerate low or moderate intensity statins as evidenced by one of the following intolerable and persistent (i.e. more t than 2 weeks) symptoms:** □ Myalgia (muscle symptoms without CK elevations) □ Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])
□ Yes □ No	**Has the physician provided medical records documenting the patient experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the physician provided medical records documenting the patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the physician provided medical records documenting the patient has a history of contraindication or intolerance to ezetimibe?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the physician provided medical records documenting that the patient has a history of failure after 12 consecutive weeks of Praluent at the FDA maximum labeled dosing of 150mg every 2 weeks?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of intolerance to Praluent therapy?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY	
□ Yes □ No	**Is the patient continuing a low-fat diet and exercise regimen?**
□ Yes □ No	**Will Repatha be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?** *If yes, list drug:*
□ Yes □ No	**Does the patient have a positive clinical response documented by LDL-C reduction while on Repatha therapy?**
□ Yes □ No	**Does the patient continue to receive other lipid-lowering therapy (e.g., statin, LDL apheresis)?** *If yes, list lipid-lowering therapy:*
□ Yes □ No	**Will Repatha be used in combination with Juxtapid (lomitapide)?**
□ Yes □ No	**Does the patient continue to receive a statin at the maximally tolerated dose (unless the patient has documented inability to take statins)?** *(If yes, complete Section D above)*

Physician Signature: _____ **Date:** _____