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

Somavert
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 may contain 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 (if any):		

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

Medication Name	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

UnitedHealthcare Community Plan

Somavert
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Is the patient currently on Somavert therapy for acromegaly?** *If yes, list start date:*
□ **Yes** □ **No**	**Does the patient have a diagnosis of <u>acromegaly</u> by one of the following?** *(If yes, check which applies)* □ Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis □ Elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis
□ **Yes** □ **No**	**Did the patient have an inadequate response to any of the following?** *(If yes, check which applies)* □ Surgery □ Radiation therapy □ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy
□ **Yes** □ **No**	**Is the patient a candidate for any of the following?** *(If yes, check which applies. If no, list reasons in Section E above)* □ Surgery □ Radiation therapy □ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy
□ **Yes** □ **No**	**Did the patient have an inadequate response, intolerance, or contraindication to one of the following somatostatin analogs?** *(If yes, check which applies and complete Section D above)* □ Sandostatin (octreotide) or Sandostatin LAR □ Somatuline Depot (lanreotide)
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response to Somavert therapy?** *If yes, list positive response:*

Provider Signature: _____ **Date:** _____