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.uhccommunityplan.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

Sutent

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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (check which apply)

□ Gastrointestinal Stromal Tumor (GIST) □ Renal Cell Carcinoma (RCC) □ Alveolar soft part sarcoma (ASPS)
□ Angiosarcoma □ Follicular Carcinoma □ Hürthle Cell Carcinoma
□ Solitary fibrous tumor/hemangiopericytoma □ Papillary Carcinoma □ Medullary Thyroid Carcinoma
□ Recurrent Chordoma □ Thymic Carcinoma □ Surgically inaccessible meningiomas
□ Soft Tissue Sarcoma □ Thyroid Carcinoma
□ Islet Cell Tumors / Progressive Pancreatic Neuroendocrine Tumors (pNET)
□ Other. **List diagnosis:** _____

- Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? □ Yes □ No
If yes, list supported use: _____
_____

Requests for GASTROINTESTINAL STROMAL TUMOR (GIST):

- Does the patient have a history of failure, contraindication, or intolerance to Gleevec (imatinib)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Requests for RENAL CELL CARCINOMA (RCC):

- Has the disease relapsed? □ Yes □ No

- Does the patient have a medically or surgically unresectable tumor? □ Yes □ No

- Does the patient have a diagnosis of Stage IV disease? □ Yes □ No

- Will the medication be used in adjuvant setting? □ Yes □ No

- Does the patient have a high risk of recurrence following nephrectomy? □ Yes □ No

Requests for THYROID CARCINOMA:

- Is the patient's disease unresectable recurrent, persistent locoregional, or metastatic? □ Yes □ No

- Does the patient have symptomatic or progressive disease? □ Yes □ No

- Is the disease refractory to radioactive iodine treatment? □ Yes □ No

- Does the patient have progressive or symptomatic metastatic disease? □ Yes □ No

- Does the patient have a history of failure, contraindication, or intolerance to either Caprelsa (vandetanib) or Cometriq (cabozantinib)? □ Yes □ No (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Requests for CENTRAL NERVOUS SYSTEM (CNS) CANCER:

- Is the disease recurrent or progressive? □ Yes □ No

- Is further radiation not possible? □ Yes □ No

Requests for THYMIC CARCINOMA:

- Will this be used as second-line following a failure, contraindication, or intolerance to a first-line chemotherapy regimen (e.g., carboplatin/paclitaxel)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

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Member First name:	Member Last name:	Member DOB:

Requests for CONTINUATION OF THERAPY:

- Does the patient show evidence of progressive disease while on Sutent therapy? □ Yes □ No

- Is there documentation of positive clinical response to Sutent therapy? □ Yes □ No
If yes, list positive response: _____

_____

Physician Signature: _____ **Date:** _____