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

Takhzyro

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

UnitedHealthcare Community Plan

Takhzyro

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have a diagnosis of hereditary angioedema (HAE)?**
□ **Yes** □ **No**	**Is the patient's diagnosis confirmed by any of the following:** *(If yes, check which applies)* □ Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene □ A C4 level below the lower limit of normal and <u>one</u> of the following (per laboratory standard): □ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal □ C1-INH functional level below the lower limit of normal
□ **Yes** □ **No**	**Will Takhzyro be used for prophylaxis against HAE attacks?**
□ **Yes** □ **No**	**Will Takhzyro be used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda)?** *If yes, list medication/rationale:*
□ **Yes** □ **No**	**Does the prescriber attest that the patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Takhzyro?**
□ **Yes** □ **No**	**Is the patient's baseline HAE attack rate greater than or equal to one attack per 4 weeks?**
□ **Yes** □ **No**	**Will the patient receive Takhzyro 300mg every 2 weeks?**
□ **Yes** □ **No**	**Is Takhzyro prescribed by <u>one</u> of the following:** □ Immunologist □ Allergist □ Rheumatologist
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response, defined as a clinically significant reduction in the rate and/or number of HAE attacks, while on Takhzyro therapy?** *If yes, list reason:*
□ **Yes** □ **No**	**Has the patient reduced the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ruconest, Firazyr, Kalbitor) while on Takhzyro therapy?**
□ **Yes** □ **No**	**Has the patient experienced any acute HAE attacks in the previous 6 months while on Takhzyro therapy?** *If yes, list number of attacks:*
□ **Yes** □ **No**	**Will the patient receive Takhzyro 300mg for either duration?** □ Every 4 weeks □ Every 2 weeks *If yes, list rationale:*

Physician Signature: _____ **Date:** _____