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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UnitedHealthcare Community Plan

# Temodar

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

**Temodar**

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 any of the following diagnoses?** *(If yes, check which applies)*<br>□ Medulloblastoma<br>□ Glioblastoma<br>□ Primary CNS Lymphoma<br>□ Neuroendocrine and Adrenal Tumors<br>□ Sézary Syndrome (SS)<br>□ Rhabdomyosarcoma<br>□ Ewing's sarcoma family of tumors<br>□ Uterine Sarcoma<br>□ Non-Hodgkin Lymphoma (NHL)<br>□ Anaplastic Gliomas<br>□ Metastatic Lesions of the CNS<br>□ Melanoma/Uveal Melanoma<br>□ Mycosis Fungoides (MF)<br>□ Angiosarcoma<br>□ Solitary fibrous tumor/hemangiopericytoma<br>□ Mesenchymal chondrosarcoma<br>□ Small Cell Lung Cancer (SCLC)<br>□ Bone Cancer<br>□ Intracranial and Spinal Ependymoma (Excluding Subependymoma)<br>□ Low-Grade Infiltrative Supratentorial Astrocytoma/Oligodendroglioma<br>□ Unresectable or progressive retroperitoneal/intra-abdominal soft tissue sarcoma<br>□ Soft tissue sarcoma of the extremity/superficial trunk, head or neck |
| □ Yes □ No | **Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?**<br>*If yes, list supported use:* |
| **NEUROENDOCRINE AND ADRENAL TUMORS** | |
| □ Yes □ No | **Does the patient have any of the following types of neuroendocrine tumors?** *(If yes, check which applies)*<br>□ Bronchopulmonary disease<br>□ Pancreatic neuroendocrine tumors<br>□ GI tract, lung or thymus<br>□ Pheochromocytoma/paraganglioma |
| **SOFT TISSUE SARCOMA** | |
| □ Yes □ No | **Does the patient have any of the following?** *(If yes, check which applies)*<br>□ Disease synchronous stage IV<br>□ Disease has disseminated metastases |
| □ Yes □ No | **Will Temodar be used in combination with Avastin (bevacizumab)?** |
| **BONE CANCER** | |
| □ Yes □ No | **Which of the following criteria applies to the patient?** *(If yes, check which applies)*<br>□ Disease has relapsed<br>□ Disease is progressive following primary treatment<br>□ Temodar is used as second-line therapy for metastatic disease |
| □ Yes □ No | **Will Temodar be used in combination with Campostar (irinotecan)?** |
| **SMALL CELL LUNG CANCER (SCLC)** | |
| □ Yes □ No | **Does any of the following criteria apply to the patient?** *(If yes, check which applies)*<br>□ Relapse within 6 months following complete or partial response or stable disease with initial treatment<br>□ Primary progressive disease |
| **CONTINUATION OF THERAPY** | |
| □ Yes □ No | **Does the patient show evidence of progressive disease while on Temodar therapy?** |
| □ Yes □ No | **Does the patient have a documented positive clinical response to Temodar therapy?**<br>*If yes, list positive response:* |

**Physician Signature:** ______________________________ **Date:** ______________

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