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

Revlimid - Washington

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

UnitedHealthcare Community Plan

Revlimid - Washington

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 apply) □ AIDS-Related B-Cell Lymphoma □ Anemia due to Myelodysplastic Syndrome (MDS) without Deletion 5q □ B-Cell Lymphomas □ Castleman's Disease (CD) □ Chronic Lymphocytic Leukemia / Small Lymphocytic Lymphoma □ Diffuse large B-cell lymphoma □ Follicular lymphoma □ Gamma-delta T-cell lymphoma □ Gastric MALT lymphoma □ High-grade B-cell lymphoma □ Histologic Transformation of Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma □ Hodgkin Lymphoma □ Multiple Myeloma □ Mycosis Fungoides (MF) / Sezary Syndrome (SS) □ Myelodysplastic Syndromes (MDS) □ Myelofibrosis □ Myelofibrosis - Associated Anemia □ Nodal marginal zone lymphoma □ Non-gastric MALT lymphoma □ Peripheral T-cell lymphoma □ Post-Transplant Lymphoproliferative Disorders □ Primary CNS Lymphoma □ Primary cutaneous CD30 + T-cell lymphoproliferative disorders □ Primary Cutaneous Lymphomas □ Splenic marginal zone lymphoma □ Symptomatic Anemia due to Myelodysplastic Syndrome (MDS) Associated with a Deletion 5q □ Systemic Light Chain Amyloidosis □ T-cell leukemia/ lymphoma □ T-Cell Lymphomas
□ Yes □ No	**Is Revlimid being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?** *If yes, list supported use:*

MYELODYSPLASTIC SYNDROME AND MYELOFIBROSIS – ASSOCIATED ANEMIA

	What is the patient's serum erythropoietin levels? List levels: _____ mU/ml
	What is the patient's ring sideroblast percentage? _____ %
□ Yes □ No	**Is Revlimid therapy used in combination with an erythropoietin [e.g., Epogen, Procrit, Retacrit (epoetin alfa]?** *If yes, list medication:*
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to erythropoietins [e.g., Epogen, Procrit, Retacrit (epoetin alfa)]?** *(If yes, please complete Section D above)*
□ Yes □ No	**Did the patient have a response to an erythropoietin in combination with a granulocyte-colony stimulating factor (G-CSF)?** *(If yes, please complete Section D above)*

B-CELL LYMPHOMA & T-CELL LYMPHOMA

□ Yes □ No	**Will Revlimid be used as first line therapy?**

NON-HODGKIN'S LYMPHOMA

□ Yes □ No	**Is the disease relapsed or refractory?**
□ Yes □ No	**Is Revlimid used as third-line or subsequent therapy?**

CHRONIC LYMPHOCYTIC LEUKEMIA/SMALL LYMPOCYTIC LYMPHOMA

□ Yes □ No	**Is Revlimid being used for any of the following:** □ Used post first-line chemo-immunotherapy maintenance therapy □ Used post second-line maintenance therapy □ Used for relapsed or refractory disease

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Revlimid - Washington

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

CONTINUATION OF THERAPY	
□ Yes □ No	**Does the patient show evidence of progressive disease while on Revlimid therapy?**
□ Yes □ No	**Does the patient have documented evidence of symptom improvement or reduction in spleen/liver volume while on Revlimid?** *If yes, list response:*
□ Yes □ No	**Does the patient have a documented positive clinical response to Revlimid therapy?** *If yes, list response:*

Physician Signature: _____ Date: _____