

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

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____					
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

Member First name:	Member Last name:	Member DOB:
Clinical and Drug Specific Information		
ALL REQUESTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following diagnoses? (If yes, check which applies) <input type="checkbox"/> Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia <input type="checkbox"/> Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL) <input type="checkbox"/> Gastrointestinal Stromal Tumor (GIST) with PDGFRA D842V Mutation <input type="checkbox"/> Metastatic Chondrosarcoma <input type="checkbox"/> Recurrent Chordoma	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the physician attest that the patient is not a candidate for imatinib?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? <i>If yes, list supported use:</i>	
CONTINUATION OF THERAPY		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient show evidence of progressive disease while on Sprycel therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of positive clinical response to Sprycel therapy? <i>If yes, list response:</i>	

Physician Signature: _____ **Date:** _____

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