

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

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**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS:

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Gastrointestinal Stromal Tumor (GIST) | <input type="checkbox"/> Renal Cell Carcinoma (RCC) | <input type="checkbox"/> Alveolar soft part sarcoma (ASPS) |
| <input type="checkbox"/> Angiosarcoma | <input type="checkbox"/> Follicular Carcinoma | <input type="checkbox"/> Hürthle Cell Carcinoma |
| <input type="checkbox"/> Solitary fibrous tumor/hemangiopericytoma | <input type="checkbox"/> Papillary Carcinoma | <input type="checkbox"/> Medullary Thyroid Carcinoma |
| <input type="checkbox"/> Recurrent Chordoma | <input type="checkbox"/> Thymic Carcinoma | <input type="checkbox"/> Surgically inaccessible meningiomas |
| <input type="checkbox"/> Soft Tissue Sarcoma | <input type="checkbox"/> Thyroid Carcinoma | |
| <input type="checkbox"/> Islet Cell Tumors / Progressive Pancreatic Neuroendocrine Tumors (pNET) | | |
| <input type="checkbox"/> 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)

Member First name:	Member Last name:	Member DOB:
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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:** _____

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