

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:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Moderate or severe asthma <input type="checkbox"/> Chronic idiopathic urticaria
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Xolair prescribed by or in consultation with one of the following specialist? <i>(If yes, check which applies)</i> <input type="checkbox"/> Allergist-immunologist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Xolair dosing for moderate to severe persistent asthma in accordance with the United States Food and Drug Administration approved labeling? <i>If no, list reason:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Xolair dosing for chronic urticaria in accordance with the United States Food and Drug Administration approved labeling? <i>If no, list reason:</i>

MODERATE OR SEVERE ASTHMA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20) <input type="checkbox"/> Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months <input type="checkbox"/> Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) <input type="checkbox"/> Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80 percent predicted [in the face of reduced FEV1-forced vital capacity [FVC] defined as less than the lower limit of normal])
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently dependent on oral corticosteroids for the treatment of asthma?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient's baseline (pre-omalizumab treatment) serum total immunoglobulin E (IgE) level greater than or equal to 30 IU/mL and less than or equal to 1500 IU/mL?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a positive skin test or in vitro reactivity to a perennial aeroallergen?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the patient use Xolair with one maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2-agonist (LABA) product [e.g., fluticasone propionate/salmeterol (AirDuo, Advair), budesonide/formoterol (Symbicort)]? <i>If yes, list medication:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the patient use Xolair with combination therapy including <u>both</u> of the following? <input type="checkbox"/> One high-dose (appropriately adjusted for age) inhaled corticosteroid (ICS) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] <input type="checkbox"/> One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline] <i>If yes, list combination therapy:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the patient receive Xolair in combination with any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Anti-interleukin 4 therapy [e.g. Dupixent (dupilumab)] <input type="checkbox"/> Anti-interleukin 5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

CHRONIC IDIOPATHIC URTICARIA (Continued on next page)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient remain symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to, <u>two</u> H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]? <i>(If yes, complete Section D above)</i>
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Member First name:		Member Last name:		Member DOB:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Does the patient remain symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to BOTH of the following taken in combination? <i>(If yes, check which applies and complete Section D above)</i></p> <p><input type="checkbox"/> Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]</p> <p><input type="checkbox"/> ONE of the following:</p> <ul style="list-style-type: none"> - Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] - First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]* - H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)] - Leukotriene modifier [e.g., Singulair (montelukast)] 			
CONTINUATION OF THERAPY - ASTHMA					
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Is there documentation of positive clinical response as demonstrated by any of the following? <i>(If yes, check which applies)</i></p> <p><input type="checkbox"/> Decreased utilization of rescue medications</p> <p><input type="checkbox"/> Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline</p> <p><input type="checkbox"/> Reduction in frequency of exacerbations</p> <p><input type="checkbox"/> Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing)</p>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Is the patient using Xolair in combination with an ICS-containing controller medication? <i>If yes, list medication:</i></p>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Will the patient receive Xolair in combination with any of the following? <i>(If yes, check which applies)</i></p> <p><input type="checkbox"/> Anti-interleukin 4 therapy [e.g. Dupixent (dupilumab)]</p> <p><input type="checkbox"/> Anti-interleukin 5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenna (benralizumab)]</p>			
CONTINUATION OF THERAPY - CHRONIC URTICARIA					
<input type="checkbox"/> Yes <input type="checkbox"/> No		<p>Is there documentation of positive clinical response (e.g., reduction in exacerbations, itch severity, hives) to Xolair therapy? <i>If yes, list response:</i></p>			

Provider Signature: _____ **Date:** _____

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