UnitedHealthcare Community Plan

Vitrakvi
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 may contain 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 (if any):		

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

Medication Name	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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have the presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.)?**
□ **Yes** □ **No**	**Is the disease positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)?**
□ **Yes** □ **No**	**Is the disease without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]?**
□ **Yes** □ **No**	**Is the disease one of the following?** *(If yes, check which applies)* □ Metastatic □ Unresectable
□ **Yes** □ **No**	**Does the disease meet one of the following conditions?** *(If yes, check which applies)* □ Has progressed on previous treatment (e.g., surgery, radiotherapy or systemic therapy) □ Has no satisfactory alternative treatments
□ **Yes** □ **No**	**Is Vitrakvi being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?** *If yes, list supported use:*
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Does the patient have the presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.)?**
□ **Yes** □ **No**	**Does the patient show evidence of progressive disease while on Vitrakvi therapy?**
□ **Yes** □ **No**	**Is there documentation of a positive clinical response to therapy?** *If yes, list response:*

Provider Signature: ____ **Date:** __________________

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