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

Xolair

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

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Xolair

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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 any of the following diagnoses?** *(check which applies)* □ Moderate or Severe Asthma □ Chronic Urticaria *If no, list diagnosis:*
□ **Yes** □ **No**	**Is Xolair prescribed by or in consultation with one of the following specialist?** □ Allergist/immunologist □ Pulmonologist □ Dermatologist
□ **Yes** □ **No**	**Is the Xolair dosing for moderate to severe persistent asthma in accordance with the United States Food and Drug Administration approved labeling?** If no, List reason:
□ **Yes** □ **No**	**Is the Xolair dosing for chronic urticaria in accordance with the United States Food and Drug Administration approved labeling?** If no, List reason:
MODERATE OR SEVERE ASTHMA	
□ **Yes** □ **No**	**Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by at least <u>one</u> of the following:** □ 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) □ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months □ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment) □ Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
□ **Yes** □ **No**	**Is the patient's baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1500 IU/mL?** *If yes, List results:_____ IU/mL*
□ **Yes** □ **No**	**Did the patient have a positive skin test or in vitro reactivity to a perennial aeroallergen?**
□ **Yes** □ **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 (Advair), budesonide/formoterol (Symbicort)]?** *If yes, list medication:*
□ **Yes** □ **No**	**Will the patient use Xolair with combination therapy including <u>both</u> of the following:** □ One high-dose (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone zuroate (Asmanex), beclomethasone dipropionate (QVAR)] □ One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline] *List combination therapy:*
□ **Yes** □ **No**	**Will the patient receive Xolair in combination with <u>either</u> of the following:** *(check which applies)* □ Nucala (mepolizumab) □ Cinqair (reslizumab)
CHRONIC URTICARIA	
□ **Yes** □ **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)]?** *(If yes, complete Section D above)*

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Member First name:	Member Last name:	Member DOB:

□ **Yes** □ **No**	**Does the patient remain symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to <u>both</u> of the following taken in combination:** *(check which applies)* □ Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] □ One of the following: - 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)] *(If yes, complete Section D above)*
CONTINUATION OF THERAPY - ASTHMA	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response (e.g., reduction in exacerbations) to Xolair therapy?**
□ **Yes** □ **No**	**Is the patient using Xolair in combination with an ICS-containing controller medication?** *If yes, list medication:*
□ **Yes** □ **No**	**Is the patient receiving Xolair in combination with <u>either</u> of the following:** *(check which applies)* □ Nucala (mepolizumab) □ Cinqair (reslizumab)
CONTINUATION OF THERAPY – CHRONIC URTICARIA	
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response (e.g., reduction in exacerbations) to Xolair therapy?** *If yes, list response:*

Physician Signature: _____ Date: _____