

**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](http://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  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 at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
---------------------------	--------------------------	--------------------

**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic or smoldering T-cell leukemia/lymphoma</li> <li><input type="checkbox"/> Primary cutaneous marginal zone or follicle center B-cell lymphoma</li> <li><input type="checkbox"/> Lymphomatoid papulosis (LyP) with extensive lesions</li> <li><input type="checkbox"/> Mycosis fungoides (MF)/Sezary Syndrome (SS)</li> </ul>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Is the disease stage IVA<sub>1</sub>, IVA<sub>2</sub> or IVB?</b></p>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Is Valchlor being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?</b></p> <p><i>If yes, list supported use:</i></p>

**CONTINUATION OF THERAPY**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have a diagnosis of non-Hodgkin lymphoma (NHL)?</b></p>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient show evidence of progressive disease while on Valchlor?</b></p>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have a documented positive clinical response to Valchlor therapy?</b></p> <p><i>If yes, list positive clinical benefit:</i></p>

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.