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.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: | Date of Birth: | Height: | Weight:

Address: | Apartment #:

City: | State: | Zip:

Phone Number: | Alternate Phone: | Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: | Provider ID Number:

Address: | City: | State: | Zip:

Suite Number: | Building Number:

Phone Number: | Fax number:

Provider's Specialty:

Medication Information

Medication: | Quantity: | ICD10 Code:

Directions: | Diagnosis: | Refills:

Physician Signature**: | DAW (Initial here):

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 **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****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

ENBREL, HUMIRA, CIMZIA, SIMPONI

PRIOR AUTHORIZATION REQUEST FORM

Please complete form and Fax to: 866-940-7328

(NOTE: This form contains 2 pages. Failure to complete in entirety will delay decision)

Today's Date

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication to be Administered: ☐ Physician's Office ☐ Patient's Home

Deliver Rx to: ☐ Physician's Office ☐ Other Address: _____

☐ Patient's Home _____

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Please fill out information for appropriate diagnosis below:

For Patients with Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Juvenile Rheumatoid Arthritis, or Psoriatic Arthritis (And Any diagnosis not specifically addressed on this form):

Will the patient be receiving treatment with more than one immunomodulator at the same time? Yes or No (Circle Answer)
These include the following: Enbrel (etanercept), Humira (adalimumab), Orencia (abatacept), Cimzia (certolizumab pegol), Kineret (anakinra), Simponi (golimumab), Stelara (ustekinumab), Remicade (infliximab), Rituxan (rituximab), Actemra (tocilizumab), Tysabri (natalizumab), Amevive (alefacept)

Has the patient been previously treated with methotrexate? Yes or No (Circle Answer) If yes please provide dates of methotrexate therapy: _____

Did previous treatment with methotrexate result in treatment failure, an intolerance/ adverse reactions, or does the patient have a documented contraindication to treatment with methotrexate? Yes or No (Circle Answer) If yes, please provide details about intolerance / adverse reaction / contraindication: _____

_____

Has the patient been previously treated with two or more of the following listed medications? Yes or No (Circle Answer)
Azathioprine, Cyclosporine, Gold compounds (e.g. Ridaura), Hydroxychloroquine, Leflunomide, Penicillamine, Sulfasalazine
If yes, Please list medication(s) tried and dates of therapy: _____

_____

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Did previous treatment with two or more of the listed medications result in treatment failure, an intolerance/ adverse reactions, or does the patient have a documented contraindication to treatment with two or more of the listed medications?
Yes or No (Circle Answer)
If yes, please provide details about intolerance / adverse reaction / contraindication: _____

_____

Has the patient received treatment with any of the following medications? Yes or No (Circle Answer) *These include the following: Enbrel (etanercept), Humira (adalimumab), Orencia (abatacept), Cimzia (certolizumab pegol), Kineret (anakinra), Simponi (golimumab), Stelara (ustekinumab), Remicade (infliximab), Rituxan (rituximab), Actemra (tocilizumab), Tysabri (natalizumab), Amevive (alefacept)*
If yes please list medication(s) tried and dates of therapy : _____

For Patients with Plaque Psoriasis:

Has the patient previously received phototherapy, or is not a candidate for phototherapy? Yes or No (Circle Answer)
Additional Notes: _____

Does the patient have a body surface area involvement of ≥ 10%? (body surface area involvement is percent of the total surface area of the body that is affected by psoriasis) Yes or No (Circle Answer)

Does the plaque psoriasis involvement affect critical areas of the body such as the palms, soles, face, or genitalia which causes interference of the patient's daily activities? Yes or No (Circle Answer)
If yes, please provide areas: _____

For Patients with Ankylosing Spondylitis:

Did previous treatment with two or more Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) result in treatment failure, an intolerance/ adverse reactions, or does the patient have a documented contraindication to treatment with two or more NSAIDs? Yes or No (Circle Answer)

List medication(s) tried and dates: _____
List adverse reaction/intolerance: _____
List contraindication: _____

For Patients with Crohn's Disease:

Is the patient's diagnosis fistulizing or non-fistulizing Crohn's disease? Fistulizing or Non-Fistulizing (Circle Answer)

Did previous treatment with at least one immunosuppressive agent result in treatment failure, an intolerance/ adverse reactions, or does the patient have a documented contraindication to treatment with at least one immunosuppressive agent?

List medication(s) tried and dates: _____
List adverse reaction/intolerance: _____
List Contraindication: _____

Did previous treatment with immunosuppressive agents and oral corticosteroids result in treatment failure, an intolerance/ adverse reactions, or does the patient have a documented contraindication to treatment with both immunosuppressive agents and oral corticosteroids?

List medication(s) tried and dates: _____
List adverse reaction/intolerance: _____
List Contraindication: _____

Please Provide Additional Clinical Information to Support this Request: _____

_____

Physician Signature:_____ **Date:** _____