

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: _____ ICD-10 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

ARANESP, EPOGEN, PROCRIT

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
<p>Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/>? If so, start date: _____</p> <p>Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
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:		
SECTION C - MEDICAL INFORMATION		
Medication:		Strength:
Directions for use:		
Diagnosis (Please be specific & provide as much information as possible):		ICD-10 CODE:
<input type="checkbox"/> Please check here if patient has HIV/AIDS		
<p>Is the patient currently receiving chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check Answer)</p> <p>Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does this patient have Myelodysplastic Syndrome that is transfusion dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No For patients with Myelodysplastic Syndrome is the patient's serum erythropoietin < 500 mU/mL? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes provide level and date of result: _____</p> <p>Has the patient received treatment with erythropoietin in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the patient's <u>current</u> hemoglobin AND hematocrit results? <i>Please provide results below.</i> List hemoglobin and the date of the result: _____ g/dl Date: _____ List hematocrit and the date of the result: _____ % Date: _____</p> <p>Is the patient's hemoglobin and hematocrit being monitored at regular intervals? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list monitoring frequency if available: _____</p> <p>Is the patient currently receiving iron supplementation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient's iron stores been evaluated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the results indicate that the patient's iron stores are below the normal range? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide results below. Date Drawn: _____ Transferrin saturation: _____ % Ferritin: _____ ng/mL</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.