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: 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 ☐

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UnitedHealthcare Community Plan

Low Molecular Weight Heparin

Preferred: Lovenox

Non-Preferred: Arixtra, Fragmin, Innohep

Prior Authorization Request Form

Complete ENTIRE form and Fax to 866-940-7328: PAGE 1 of 2

SECTION A – PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Street Address:		
City:	State:	Zip:
Phone:	Date of Birth:	
Does this patient have other / primary insurance? ☐ YES ☐ NO *(if yes please provide primary insurance information below)*		
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: D.O./M.D.		
Address	City:	State:	Zip:
Phone:	Fax:	NPI:	Specialty::
Office Contact Name:			

SECTION C – MEDICAL INFORMATION

Medication Name & Strength:

Directions for Use:

If requesting Arixtra, Fragmin, or Innohep: Has the preferred product (Lovenox) failed to treat the patient's condition? (Check appropriate answer) ☐ YES or ☐ NO (if yes, provide details) ______________________________

What is the patient's diagnosis? (Check appropriate answer)

- ☐ Acute ST-segment elevation myocardial infarction (STEMI).
- ☐ Unstable angina/non-Q-wave myocardial infarction (MI).
- ☐ Treatment or prevention of thromboembolic disease or VTE (DVT or PE) during pregnancy
- ☐ Deep vein thrombosis (DVT) or Pulmonary Embolism (PE)
- ☐ Other. List diagnosis:____

(Additional Questions on the next page)

Please complete and return both pages of this request form along with the specialty cover sheet to avoid unnecessary delay.

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If patient is pregnant list due date: ______________________________

For non-pregnant patients: Which of the following best suits this request (check one only):

- □ Acute treatment (short-term anticoagulation needed)
- □ Long-term treatment (long term anticoagulation needed)
- □ Prevention of DVT or PE due to surgery / acute illness

Does this patient have cancer? □ YES or □ NO (if yes, provide details) ______________________________

Is the requested medication being started along with warfarin (Coumadin), and then will be discontinued when INR is in therapeutic range? □ YES or □ NO

If no, why is Coumadin not a treatment option for this patient? (Check appropriate answer)

- □ Treatment with warfarin is contraindicated in this patient. List reason: ______________________________
- □ Treatment with warfarin is not tolerated. List adverse events: ______________________________
- □ Other (please explain): ______________________________

For LONG TERM requests: For what reason is long term treatment with the requested mediation needed? (Check appropriate answer)

- □ Recurrent DVT
- □ Recurrent PE
- □ Other (please explain): ______________________________

For PREVENTION of DVT or PE due to surgery / acute illness: What type of prevention is the requested medication being used for? (Check appropriate answer)

- □ Knee arthroplasty (replacement)
- □ Hip arthroplasty (replacement)
- □ Status post-surgery (example: major general surgery, vascular surgery, gynecological surgery)
- □ DVT or PE prevention in cancer patients
- □ DVT or PE prevention in patients with severely restricted mobility during acute illness
- □ Other (please explain): ______________________________

Additional clinical information: ______________________________

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Please Note: The Plan provides up to a 14 day supply of enoxaparin at the point of sale without prior authorization every 90 days.

Physician Signature: ______________________________ Date: ______________

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