

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

ORAL CHEMOTHERAPY PRIOR AUTHORIZATION REQUEST

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

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 <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:	Last Name:		
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
SECTION C - MEDICAL INFORMATION			
Medication:	Strength:	Frequency of Dosage:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE:
Is the requested agent being used as first line therapy? Yes or No (<i>circle Answer</i>)			
If No, please fill out the following table (Please include both Oral and IV therapies):			
Previous Medication Regimens:			
Drug Name, Strength, and Directions for Use	Dates of Therapy	Reason for Discontinuing Therapy	
Will the requested product be used alone or in combination with another agent? _____			
If being used as part of combination therapy please list chemotherapy regimen: _____			

Affinitor Requests:			
Is the patient's condition unresectable, locally advanced, or metastatic? Yes or No (<i>Circle answer</i>)			
Hycamtin Requests: (<i>Circle answer</i>)			
Has at least 45 days passed since the end of the patient's treatment with first line chemotherapy? Yes or No			
Temodar Requests:			
Temodar be used with radiotherapy? Yes_ or_ No_ (<i>Circle answer</i>)			
Tykerb Requests:			
Is the Patient post-menopausal? Yes or No (<i>Circle Answer</i>)			
Xeloda or Gleevec Requests:			
Has the patient undergone complete resection of the primary tumor? Yes_ No_ (<i>Circle answer</i>)			
If this is a request for reauthorization, has this patient benefited from current therapy? Yes or No (<i>Circle answer</i>)			
Additional clinical information to support this request:			

Physician Signature: _____ Date: _____

Confidentiality Notice: This transmission contains confidential information belonging to the sender and United Healthcare. This information is intended only for the use of United Healthcare. 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.