

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



XOLAIR

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 #:

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: _____

SECTION C - MEDICAL INFORMATION

Medication:	Strength:
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Directions for use: _____

Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
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Does the patient have a confirmed diagnosis of moderate to severe persistent asthma?

(Circle Response) YES or NO

Has this patient tested positive to at least one perennial aeroallergen by a skin test or blood test?

(Circle Response) YES or NO

If yes, please specify test type: _____

What is the patient's serum baseline IgE level? _____

For Reauthorization Requests:

Has Xolair provided clinical benefit for the patient as evidenced by a reduction in the amount of asthma exacerbations? *(Circle Response)* YES or NO

Other Medications tried

Medication, Strength, and Directions for Use	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____

Date: _____

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