UnitedHealthcare Community Plan

24 Hour Urgent
Prior Authorization Request Form
Fax back to**: 866-940-7328**

Specialty Medication Prior Authorization Cover Sheet

Please fax this cover sheet along with a Pharmacy Prior Authorization Medication Fax Request Form. If you have questions, please call 800-310-6826. Thank you for the care you give our members.

Patient

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 include 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

ENBREL, HUMIRA, CIMZIA, SIMPONI
PRIOR AUTHORIZATION REQUEST FORM

24 Hour Urgent

Please complete both pages of this form to avoid a delay in our decision and fax them to 866-940-7328.

Today's Date		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code :
Phone:	Date of Birth:	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 or Other Related Diagnoses

Will the patient be receiving treatment with more than one immunomodulator at the same time? Circle Answer) Yes or No *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? (Circle Answer) 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? (Circle Answer) Yes or No
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? Azathioprine, Cyclosporine, Gold compounds (e.g. Ridaura), Hydroxychloroquine, Leflunomide, Penicillamine, Sulfasalazine (Circle Answer) Yes or No

If yes, please list medication(s) tried and dates of therapy:_____

_____

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? (Circle Answer) Yes or No If yes, please provide details about intolerance / adverse reaction / contraindication: _____

Has the patient received treatment with any of the following medications? (Circle Answer) Yes or No *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? (Circle Answer) Yes or No
Additional Notes: _____

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

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? (Circle Answer) Yes or No

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? (Circle Answer) Yes or No
List medication(s) tried and dates: _____
List adverse reaction/intolerance/contraindication: _____

For Patients with Crohn's Disease:

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

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/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? (Circle Answer) Yes or No
List medication(s) tried and dates: _____
List adverse reaction/intolerance/contraindication: _____

For All Requests:

Please provide additional clinical information to support this request: _____

If continuation, has the patient had a positive clinical response to therapy? □ Yes □ No

If yes, list clinical details: _____

Physician Signature:_____ **Date:** _____

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