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 Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

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 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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Praluent
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list 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 code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication: **Strength:**

Dispense as Written: □ Yes □ No

Directions for use: **Quantity:**

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date?** _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

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Clinical and Drug Specific Information

- What is the prescriber's specialty? (check which applies)
□ Cardiologist □ Endocrinologist □ Lipid Specialist □ Other, List: _____

- Will Praluent be used in combination with another proprotein convertase substilisin/kexin type 9 (PCSK9) inhibitor? □ Yes □ No
If yes, list drug: _____

- Will Praluent be used as an adjunct to a low-fat diet and exercise regimen? □ Yes □ No

- Does the patient have primary hyperlipidemia and one of the following diagnoses? □ Yes □ No (check which applies)
□ Heterozygous Familial Hypercholesterolemia (HeFH) □ Atherosclerotic Cardiovascular Disease (ASCVD)
□ Other, List: _____

Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)

- What is the patient's pre-treatment LDL-C level? _____mg/dL date of test: _____
(Please attach medical records for confirmation of information (e.g., chart notes, laboratory values)

- Has the patient's diagnosis been confirmed by medical records documenting pre-treatment LDL-C levels greater than 190mg/dL in an adult first- or second- degree relative? □ Yes □ No
(Please attach medical records for confirmation of information (e.g., chart notes, laboratory values)

If yes, list LDL-C level: _____ mg/dL date of test: _____ Relative: _____

Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD)
Heterozygous Familial Hypercholesterolemia (HeFH)

- Has the patient's diagnosis been confirmed by one of the following? □ Yes □ No (check which applies)
□ Acute coronary syndromes
□ History of myocardial infarction
□ Stable or unstable angina
□ Coronary or other arterial revascularization
□ Stroke
□ Transient ischemic attack
□ Peripheral arterial disease presumed to be of the atherosclerotic origin

- Is the patient unable to tolerate low- moderate- and high-intensity statins due to Myalgia or Myositis? □ Yes □ No
If yes, list symptom and duration: _____
(please attach medical records, e.g., chart notes, laboratory values to support your answer)

- Has the patient received therapy, and will continue to receive therapy at a maximally tolerated dose, with any of the following: □ Yes □ No (check which applies, and fill out medication information for each)

□ High-intensity statin therapy
List medication, dose, start date and end date: _____
□ Moderate-intensity statin therapy
List medication, dose, start date and end date: _____
□ Low-intensity statin therapy
List medication, dose, start date and end date: _____

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- **Has the patient undergone a trial of statin rechallenge with another low-intensity statin with documented reappearance of muscle symptoms? □ Yes □ No**
  If yes, list medication, dose and trial dates: _____

- **Does the patient have a labeled contraindication to all statins? □ Yes □ No**
  If yes, list contraindication: _____

- **Has the patient experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN? □ Yes □ No**
  (please attach medical records, e.g., chart notes, laboratory values to support your answer)

- **Has the patient had therapy with Zetia as adjunct to maximally tolerated statin therapy and will continue to receive Zetia? □ Yes □ No**
  If yes, list dates of therapy: _____

- **Does the patient have a history of contraindication or intolerance to Zetia? □ Yes □ No**
  If yes, list dates of therapy and reason for d/c: _____

- **What is the patient's LDL-C value while on maximally tolerated lipid lowering therapy? _____mg/dL (result must be within last 30 days, please attach lab results)**

Continuation of Therapy Requests

- **Does the patient have primary hyperlipidemia? □ Yes □ No**

- **Will the patient continue to receive a statin at the maximally tolerated dose? □ Yes □ No**

- **Will the patient continue to receive Zetia as an adjunct to maximally tolerated statin therapy? □ Yes □ No**

- **Has there been a LDL-C reduction while on Praluent therapy? □ Yes □ No (please attach lab results)**
  If yes, list previous LDL-C value and date: _____mg/dL
  List current LDL-C value and date: _____mg/dL

- **Is the patient continuing a low-fat diet and exercise regimen? □ Yes □ No**

Physician Signature: _____ Date: _____