

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 If recently discharged, list discharge date: \_\_\_\_\_

**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**

<b>Medication:</b>	<b>Strength:</b>
<b>Directions for use:</b>	<b>Quantity:</b>
<b>Diagnosis</b> (Please be specific & provide as much information as possible):	<b>ICD-10 CODE:</b>
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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 and Explanation of why preferred medications would not meet the patient's needs**  
*Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for a list of preferred alternatives*

Member First name:	Member Last name:	Member DOB:
<b>Clinical and Drug Specific Information</b>		
<p><b>- What is the patient's diagnosis?</b>  <input type="checkbox"/> Non-Small Cell Lung Cancer <input type="checkbox"/> Soft Tissue Sarcoma <input type="checkbox"/> Other, list diagnosis: _____</p> <p><b><u>Requests for Non-Small Lung Cancer:</u></b>  <b>- Is the patient's disease metastatic or recurrent?</b> <input type="checkbox"/> Metastatic <input type="checkbox"/> Recurrent</p> <p><b>- Is the tumor anaplastic lymphoma kinase (ALK)-positive?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>Requests for Soft Tissue Sarcoma:</u></b>  <b>- Does the patient have a diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>Requests for Continuation of Therapy:</u></b>  <b>- Does the patient show evidence of progressive disease while on Zykadia therapy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Website: [uhcommunityplan.com](http://uhcommunityplan.com)