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.uhcprovider.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**: Initial here if DAW:

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 continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****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 ☐

UnitedHealthcare Community Plan

Afinitor – Washington

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 Information:		

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 - Provider 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:**
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 and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Afinitor – Washington

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does the patient have any of the following diagnoses?** *(check which apply)* □ Advanced Renal Cell Carcinoma □ Breast Cancer □ Classical Hodgkin Lymphoma □ Endometrial Carcinoma □ Follicular carcinoma □ Gastrointestinal Stromal Tumor (GIST) □ Hodgkin Lymphoma □ Hürthle cell carcinoma □ Lymphangioleiomyomatosis □ Lymphoplasmacytic Lymphoma □ Meningioma □ Neuroendocrine Tumors □ Papillary carcinoma □ PEComa (perivascular epithelioid cell tumor) □ Recurrent angiomyolipoma □ Renal Angiomyolipoma and Tuberous Sclerosis Complex (TSC) □ Renal Cell Cancer □ Soft Tissue Sarcoma □ Subependymal Giant Cell Astrocytoma (SEGA) with Tuberous Sclerosis Complex □ Thymic Carcinoma □ Thymoma □ Thyroid Carcinoma □ Tuberous Sclerosis Complex associated Partial-Onset Seizures □ Waldenström's Macroglobulinemia
□ Yes □ No	**Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?** *If yes, list supported use:*
NEURIENDOCRINE TUMORS	
□ Yes □ No	**Does the patient have one of the following diagnoses?** *(check which apply)* □ Neuroendocrine tumors of pancreatic origin □ Neuroendocrine tumors of gastrointestinal origin □ Neuroendocrine tumors of lung origin □ Neuroendocrine tumors of thymic origin
□ Yes □ No	**Is the patient's disease progressive?**
□ Yes □ No	**Does the patient have unresectable, locally advanced, or metastatic disease?**
ADVANCED RENAL CELL CANCER	
□ Yes □ No	**Has the patient's disease relapsed?**
□ Yes □ No	**Does the patient have a medically or surgically unresectable tumor?**
□ Yes □ No	**Does the patient have a diagnosis of Stage IV disease?**
□ Yes □ No	**Does the patient have non-clear cell histology?**
□ Yes □ No	**Does the patient have predominantly clear cell histology?**
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to at least one prior tyrosine kinase inhibitor therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)]?** *(If yes, complete Section D above)*
RENAL ANGIOMYOLIPOMA AND TUBEROUS SCLEROSIS COMPLEX (TSC)	
□ Yes □ No	**Does the patient require immediate surgery?**
SUBEPENDYMAL GIANT CELL ASTROCYTOMA	
□ Yes □ No	**Does the patient have a diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)?**
□ Yes □ No	**Is the patient a candidate for curative surgical resection?**
WALDENSTRÖM'S MACROGLOBULINEMIA OR LYMPHOPLASMACYTIC LYMPHOMA	
□ Yes □ No	**Does one of the following apply to the patient?** *(check which apply)* □ Disease is non-responsive to primary treatment □ Disease is progressive □ Disease has relapsed
BREAST CANCER	
□ Yes □ No	**Is the patient's disease recurrent or metastatic?**

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PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Is the patient's disease hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]?**
□ Yes □ No	**Does the patient have hormone receptor negative (HR-) disease?**
□ Yes □ No	**Does the disease have clinical characteristics that predict an HR+ tumor?**
□ Yes □ No	**Is the patient's disease human epidermal growth factor receptor 2 (HER2)-negative?**
□ Yes □ No	**Is the patient postmenopausal or premenopausal?** *(check which applies)* □ Postmenopausal □ Premenopausal
□ Yes □ No	**Is the patient being treated with ovarian ablation/suppression?**
□ Yes □ No	**Will Afinitor be used in combination with any of the following?** *(check which applies)* □ Aromasin (exemestane) □ Faslodex (Fulvestrant) □ Tamoxifen
□ Yes □ No	**Has the patient's disease progressed while on or within 12 months of non-steroidal aromatase inhibitor therapy [e.g., Arimidex (anastrozole), Femara (letrozole)]?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient been treated with tamoxifen at any time?** *(If yes, complete Section D above)*
HODGKIN LYMPHOMA	
□ Yes □ No	**Does the patient have relapsed or refractory disease?**
SOFT TISSUE SARCOMA	
□ Yes □ No	**Has the disease progressed after single agent therapy?**
□ Yes □ No	**Will Afinitor be used in combination with <u>one</u> of the following:** *(check which applies)* □ Gleevec (imatinib) □ Sutent (sunitinib) □ Stivarga (regorafenib)
BONE CANCERS – THYMOMAS - THYMIC CARCINOMAS	
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to at least <u>one</u> prior first-line chemotherapy regimen?** *(If yes, complete Section D above)*
THYROID CARCINOMA	
□ Yes □ No	**Does the patient have one of the following?** *(check which applies)* □ Unresectable locoregional recurrent □ Persistent □ Metastatic
□ Yes □ No	**Does the patient have symptomatic or progressive disease?**
□ Yes □ No	**Is the disease refractory to radioactive iodine treatment?**
MENINGIOMA	
□ Yes □ No	**Does the patient have recurrent or progressive disease?**
□ Yes □ No	**Is surgery and/or radiation not possible?**
ENDOMETRIAL CARCINOMA	
□ Yes □ No	**Will Afinitor be used in combination with letrozole?**
TUBEROUS SCLEROSIS COMPLEX ASSOCIATED PARTIAL-ONSET SEIZURES	
□ Yes □ No	**Will Afinitor be used as adjunctive therapy?** *If yes, list:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Does the patient show evidence of progressive disease while on Afinitor therapy?** *If yes, list response:*
□ Yes □ No	**Does the patient have a documented positive clinical response to Afinitor therapy?** *If yes, list response:*

Physician Signature: _____ **Date:** _____