UnitedHealthcare Community Plan

Cytokine & CAM Antagonists - 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 may contain 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 (if any):		

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

Medication Name	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

UnitedHealthcare Community Plan

Cytokine & CAM Antagonists - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check which applies)

□ Active Ankylosing Spondylitis
□ Moderate to severe hidradenitis suppurativa
□ Moderate to severe chronic plaque psoriasis
□ Moderately to severely active rheumatoid arthritis
□ Non-infectious uveitis
□ Moderately to severely active Crohn's disease
□ Moderately to severely active juvenile idiopathic arthritis
□ Active psoriatic arthritis
□ Moderately to severely active ulcerative colitis
□ Other: List diagnosis: ___________________________________

- Will the requested medication be used in combination with any of the following? □ Yes □ No

□ Biologic DMARD
□ Janus kinase inhibitor
□ Phosphodiesterase 4 (PDE4) inhibitor

- Does the patient have a negative TB test? □ Yes □ No

- Is the medication being prescribed by or in consultation with any of the following? □ Yes □ No
(check which applies) □ Rheumatologist □ Gastroenterologist □ Dermatologist

- Does the patient have a history of failure, contraindication, or intolerance to conventional therapy? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Has the patient demonstrated failure or intolerance to a majority of the preferred Cytokine and CAM Antagonists?
□ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
If no, list reason: ____

Requests for ANKYLOSING SPONDYLITIS & IDIOPATHIC ARTHRITIS::

- Does the patient have a history of failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a history of failure, contraindication, or intolerance to a non-biologic DMARD (methotrexate, acetretin, or cyclosporine)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for CROHNS DISEASE & HIDRADENITIS SUPPURATIVA:

- Does the patient have a history of failure, contraindication, or intolerance to Humira? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for PLAQUE PSORIASIS:

- Does the patient have a history of failure, contraindication, or intolerance to phototherapy? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a history of failure, contraindication, or intolerance to other systemic therapies? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for PSORIATIC ARTHRITIS & RHEUMATOID ARTHRITIS:

- Does the patient have a history of failure, contraindication, or intolerance to non-biologic DMARDs (methotrexate, acetretin, or cyclosporine)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a history of failure, contraindication, or intolerance to at least 2 preferred biologic agents?
□ Yes □ No

Requests for UVEITIS:

- Is the patient's uveitis classified as one of the following: □ Yes □ No (check which applies)
□ Intermediate □ Posterior □ Panuveitis □ Other

UnitedHealthcare Community Plan

Cytokine & CAM Antagonists - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Requests for CONTINUATION OF THERAPY:

- **Is the patient currently stable on therapy? □ Yes □ No**
- **Has the provider documented a positive clinical response to therapy? □ Yes □ No**
  If yes, list positive response: ____

Provider Signature: ______________________________ Date: ________________

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.