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

Hematopoietic Agents Thrombopoiesis Stimulating Proteins – 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 at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Hematopoietic Agents Thrombopoiesis Stimulating Proteins – 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?** *(If yes, check which applies)* □ Chronic immune thrombocytopenic purpura (ITP) □ Aplastic anemia □ Chronic hepatitis C-associated thrombocytopenia □ Thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure
	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA
□ **Yes** □ **No**	**Is there documentation of platelet count of less than 30 x 10^9/L (30,000/mm^3)?**
□ **Yes** □ **No**	**Does the patient have history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Corticosteroids □ Immunoglobulins □ Rituximab □ Previous history of splenectomy
	APLASTIC ANEMIA
□ **Yes** □ **No**	**Does the patient have history of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy which includes but is not limited to the following?** *(If yes, check which applies and complete Section D above)* □ Antithymocyte globulin equine (Atgam) □ Antithymocyte globulin rabbit (Thymoglobulin) □ Cyclosporine
	CHRONIC HEPATITIS C-ASSOCIATED THROMBOCYTOPENIA
□ **Yes** □ **No**	**Is thrombocytopenia preventing the initiation of interferon-based therapy or limiting the ability to maintain an interferon-based therapy?**
□ **Yes** □ **No**	**Does the patient have any of the following:** *(If yes, check which applies)* □ A reason why the patient cannot use direct acting antivirals for hepatitis C □ Planning to initiate and maintain interferon-based treatment □ Currently receiving interferon-based treatment
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Is there documentation of positive clinical response (e.g., increase in platelet count)?**
	CONTINUATION OF THERAPY- PROMACTA – CHRONIC HEPATITIS C WITH THROMBOCYTOPENIA
□ **Yes** □ **No**	**Is the patient currently on interferon-based therapy for treatment of chronic hepatitis C?**
□ **Yes** □ **No**	**Is there documentation of positive clinical response (e.g., increase in platelet count)?**

Physician Signature: _____ **Date:** _____