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

# Tafinlar - 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

# Tafinlar - 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 one of the following:** *(If yes, check which applies)*<br>□ Unresectable Melanoma □ Melanoma involving the lymph nodes<br>□ Metastatic Melanoma □ Non-Small Cell Lung Cancer (NSCLC)<br>□ Metastatic Brain Lesions □ Anaplastic Thyroid Cancer (ATC)<br>□ Central Nervous System (CNS) Cancers □ Follicular, Hurthle cell, or papillary carcinoma |
| □ Yes □ No | **Is the medication being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?**<br>*If yes, list supported use:* |
| □ Yes □ No | **Does the patient have one of the following mutations?** *(If yes, check which applies)*<br>□ BRAF V600 □ BRAF V600E |
| | **MELANOMA** |
| □ Yes □ No | **Is this prescribed as adjuvant therapy and used in combination with Mekinist (trametinib)?** |
| | **NON-SMALL CELL LUNG CANCER** |
| □ Yes □ No | **Is the disease one of the following:** *(If yes, check which applies)*<br>□ Metastatic □ Advanced □ Recurrent |
| □ Yes □ No | **Does one of the following apply to the patient:** *(If yes, check which applies)*<br>□ Tafinlar will be used in combination with Mekinist (trametinib)<br>□ Tafinlar will be used as a single agent if the combination of Mekinist and Tafinlar is not tolerated |
| | **ANAPLASTIC THYROID CANCER (ATC)** |
| □ Yes □ No | **Will Tafinlar be used in combination with Mekinist (trametinib)?** |
| □ Yes □ No | **Is the disease one of the following:** *(If yes, check which applies)*<br>□ Metastatic □ Locally advanced □ Unresectable |
| □ Yes □ No | **Is Tafinlar prescribed as adjuvant therapy following resection?** |
| | **CENTRAL NERVOUS SYSTEM (CNS) CANCERS** |
| □ Yes □ No | **Does the patient have metastatic brain lesions?** |
| □ Yes □ No | **Is Tafinlar active against the primary tumor (melanoma)?** |
| □ Yes □ No | **Will Tafinlar be used in combination with Mekinist (trametinib)?** |
| | **FOLLICULAR/HURTHE CELL/PAPILLARY CARCINOMA** |
| □ Yes □ No | **Is the disease one of the following:** *(If yes, check which applies)*<br>□ Unresectable locoregional recurrent □ Persistent □ Metastatic |
| □ Yes □ No | **Does the patient have one of the following disease types:**<br>□ Symptomatic □ Progressive |
| □ Yes □ No | **Is the disease refractory to radioactive iodine treatment?** |
| | **CONTINUATION OF THERAPY** |
| □ Yes □ No | **Does the patient show evidence of progressive disease while on Tafinlar therapy?** |
| □ Yes □ No | **Does the patient have a documented positive clinical response to Tafinlar therapy?**<br>*If yes, list positive response:* |

**Physician Signature:** _____ **Date:** _____