UnitedHealthcare Community Plan

URGENT – 24 HOUR

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.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD9 Code:

Directions: Diagnosis: Refills:

Physician Signature**: DAW (Initial here):

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 **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****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

24 HOURS - URGENT

FLORIDA MEDICAID

Prior Authorization

Hepatitis C Medication

Complete ENTIRE form and Fax to: 866-940-7328

Note: Form must be completed in full. An incomplete form may be returned.

Member ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber NPI #

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

Requested medications (Check all that apply)

Check box if Requesting	Name of medication	Directions for use
☐	Peg-Interferon Product:	
☐	Ribavirin Product:	
☐	Sovaldi	
☐	Olysio	
☐	Other: (specify)	
☐	Other: (specify)	

1. What is the prescriber's specialty? _____

2. Is this a request to:

   ☐ Start INITIAL treatment ☐ Continue previously approved therapy ☐ Retreat patient

3. What are the patient's genotype AND baseline HCV RNA?

Genotype		Collection Date:	
Baseline HCV RNA Viral load		Collection Date:	

Must submit copy of labs with a collection date within the past 3 months

4. Has the patient abstained from the use of illicit drugs and alcohol for a minimum of one month as evidence by a negative urineor blood confirmation test collected within the past 30 days prior to initiation of therapy? ***Results must be submitted with this request***

☐ YES ☐ NO

5. Is this patient receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment? ***Must submit medical records to support if YES***

☐ YES ☐ NO

6. Has the patient agreed to complete the regimen documented in medical records? ***Please submit medical record documentation if YES***

☐ YES ☐ NO

7. Has the patient verbally or in writing committed to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment? ***Please submit medical record documentation if YES***

☐ YES ☐ NO

8. If the patient is a female, does the patient have documentation of a negative pregnancy test collected within 30 days prior to initiation of therapy OR medical records documenting pregnancy status as negative?

☐ YES ☐ NO

9. Does this patient have co-infection with HIV-1? ☐ YES ☐ NO

   a. If yes, is this patient taking antiretroviral therapy? ☐ YES ☐ NO

   b. What is this patient's CD4 count? _____ Date collected:_____

10. Does this patient have stage 3 or stage 4 hepatic fibrosis? ☐ YES ☐ NO

    If yes, must submit medical record evidence to support

11. Does the patient have a decompensated liver disease defined as Child-Pugh score greater than 6 (Class B or C)? ☐ YES ☐ NO

12. Is this patient ineligible for treatment with peginterferon alfa? ☐ YES ☐ NO
    If yes, please provide rationale:

    _____

13. *For Re-Authorization Requests:* Has the patient demonstrated signs of high risk behavior (recurring alcohololism, IV drug abuse, etc.) or failure to complete HCV disease evaluation appointments and procedures in follow-up reviews? ☐ YES ☐ NO

14. *For Re-Authorization Requests:* Has the patient been 100% compliant to the treatment plan?
    ☐ YES ☐ NO

Hepatitis C Medication Management Program
Treatment Documentation Requirements
(Please submit copies of all required labs along with this request)

Date that treatment was started: _____

Baseline HCV-RNA: _____ Date Collected: _____

Please check appropriate regimen and provide copies of labs:

☐ Genotype 1		
☐ Sovaldi, Peginterferon, Ribavirin (12 weeks)	Labs required at week 4:	Date drawn:
☐ Sovaldi, Ribavirin (24 weeks)	Labs required at week 4: Labs required at week 12:	Date drawn: Date drawn:
☐ Sovaldi, Olysio (12 weeks)	Labs required at week 4:	Date drawn:
☐ Genotype 2		
☐ Sovaldi, Ribavirin (12 weeks)	Labs required at week 4:	Date drawn:
☐ Sovaldi, Ribavirin (16 weeks – decompensated patients)	Labs required at week 4: Labs required at week 12:	Date drawn: Date drawn:
☐ Genotype 3		
☐ Sovaldi, Ribavirin (24 weeks)	Labs required at week 4: Labs required at week 12:	Date drawn: Date drawn:
☐ Genotype 4		
☐ Sovaldi, Peginterferon, Ribavirin (12 weeks)	Labs required at week 4:	Date drawn:
☐ Sovaldi, Ribavirin (24 weeks)	Labs required at week 4: Labs required at week 12:	Date drawn: Date drawn:
☐ Hepatocellular Carcinoma		
☐ Sovaldi, Ribavirin (48 weeks)	Labs required at week 4: Labs required at week 12: Labs required at week 24:	Date drawn: Date drawn: Date drawn:

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.
