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.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 ☐

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GROWTH HORMONE
PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 1-866-940-7328

Today's Date:

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication to be Administered: ☐ Physician's Office ☐ Patient's Home

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

DIAGNOSIS

Pediatric

☐ **Growth hormone Deficiency (283.3)**
- ☐ Hypopituitarism (253.7)
- ☐ Panhypopituitarism (253.2)

☐ **Short Stature/ Growth Failure / Growth Retardation (783.43)**

☐ **Small for Gestational Age (764.00), plus**
- ☐ Short Stature/ Growth Failure (783.43)
- ☐ Russell Silver Syndrome (759.89)

☐ **SHOX Deficiency (766.80)**

☐ **Turner Syndrome (766.80)**

☐ **HIV/AIDS**

PLEASE NOTE: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. Coverage for this indication may vary based on design benefit.

Adult

☐ **Growth Hormone Deficiency (253.5)**
- ☐ Hypopituitarism (253.7)
- ☐ Panhypopituitarism (253.2)

Onset of Growth Hormone Deficiency:

☐ Childhood Onset

☐ Adult Onset

☐ **HIV/AIDS**

Is patient currently receiving growth hormone therapy? □ **Yes** □ **No**

If yes, for how long? **(Please provide start date)** _____

Note: ALL of the required medical assessment information MUST be completed and ALL pertinent laboratory and clinical documentation MUST be submitted with the request in order to complete the review and render a determination. Incomplete requests will only delay the review process and/or result in a denial for insufficient clinical information

PhysicianSignature:_____**Date:**_____

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MEDICAL ASSESSMENT AND LABORATORY VALUES ********** DOCUMENTATION MUST BE ATTACHED **********	**Required for Both Pediatric and Adult Patients:**
	☐ Current History / Physical Examination and Relevant Chart Notes ☐ IGF-1 Results _____ Dates: _____ ☐ Thyroid Function Test Results _____ Dates: _____ ☐ Growth Hormone Stimulation Test Results Agent _____ Peak GH _____ Dates: _____ Agent _____ Peak GH _____ Dates: _____ ☐ MRI Scan Results _____ Dates: _____
	Required for Pediatric Patients Only:
	☐ Height _____ cm _____ %tile Dates: _____ ☐ Weight _____ kg _____ %tile Dates: _____ ☐ Height Velocity _____ cm/ year Dates: _____ ☐ Mean Height _____ cm ☐ Height Standard Deviation (+) or (-) _____ ☐ Chronological Age _____ yrs._____ mos. Date: _____
	☐ Bone Age _____ yrs._____ mos. Date: _____
	Epiphyses: ☐ Open ☐ Closed Attach most recent radiological report: Date performed: _____
	☐ Predicted Adult Height _____ ___ cm Date: _____
	☐ Growth Chart Attached Date: _____

PhysicianSignature:_____ **Date:**_____