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: ICD10 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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URGENT – 24 HOUR

Hepatitis C Medication
PRIORAUTHORIZATION REQUEST FORM

Please complete both pages of form and Fax to: 866-940-7328

(NOTE: This form contains 2 pages. Failure to complete in entirety will delay decision.)

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:				

SECTION C - MEDICAL INFORMATION	
☐ **Ribavirin Product Requested (Include Strength):**	**Ribavirin Directions for Use:**
☐ **Interferon Product Requested (Include Strength):**	**Interferon Directions for Use:**
☐ **Sovaldi**	**Sovaldi Directions for Use:**
☐ **Olysio**	**Olysio Directions for Use:**
☐ **Victrelis** ☐ **Incivek** ☐ **Other Agent**	**Directions for Use:**
Diagnosis:	**ICD 10 Code:**

This section <u>MUST</u> be completed for ALL patients with Hepatitis C

*****<u>ALL</u> supporting labs and chart documentation is required for medical review of this request*****

Genotype (*<u>MUST</u> submit supporting lab documentation*): ☐ Genotype 1 ☐ Genotype 2
☐ Genotype 3 ☐ Genotype 4 ☐ Other Genotype (Must specify) _____

Prescriber Specialty: ☐ Hepatologist ☐ Gastroenterologist ☐ Infectious Disease Specialist
☐ Other (Must specify):_____

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Hepatitis C Medication
PRIORAUTHORIZATION REQUEST FORM

Has this patient been treated for Hepatitis C previously? □ YES □ NO
If yes, must provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing:

Trial	Regimen (List all medications tried with each trial)	Dates of Therapy	Treatment Completed Yes or No	Outcome of Treatment or Reason for Discontinuation
1				
2				

Has drug / alcohol abuse been discussed with this patient? □ YES □ NO
Has a drug screen been completed <u>in the last 90 days</u>? □ YES □ NO ***<u>MUST</u> SUBMIT RESULTS***
<u>Must</u> provide documentation to confirm baseline negative drug screen results* ***within the last 90 day

Does the patient have decompensated liver disease defined as a Child-Pugh class B or C? (*Must submit supporting labs and chart documentation*) □ YES □ NO
What is this patient's Child-Pugh Class? _____

Does the patient have hepatocellular carcinoma? □ YES □ NO
If yes, is this patient awaiting a liver transplant? □ YES □ NO

*****THIS SECTION <u>MUST</u> BE COMPLETED FOR PATIENTS WITH GENOTYPE 1*****

Are you requesting an interferon free regimen for this patient? □ YES □ NO
If yes, what is the clinical rationale for requesting an interferon free regimen? (<u>Must</u> include chart documentation to support response) _____
_____

Does this patient have evidence of stage 3 or stage 4 hepatic fibrosis that includes one of the following? (*<u>Must</u> submit supporting labs and chart documentation*) □ YES □ NO

- **Liver biopsy confirming a METAVIR score of F3 or F4 or an alternative scoring equivalent**
- **Transient elastography (Fibroscan) score greater than or equal to 9.5kPa**
- **FibroTest (FibroSURE) score of greater than or equal to 0.58**
- **APRI score greater than 1.5**
- **Radiological imaging consistent with cirrhosis**
- **Physical findings or clinical evidence consistent with cirrhosis documented in the patient's chart**

Does the patient have NS3 Q80K polymorphism? □ YES □ NO *If yes, <u>must</u> submit supporting labs*

Does the patient have IL28B-CC genotype status? □ YES □ NO *If yes, submit supporting labs*

****ALL supporting labs and chart documentation is required for medical review of this request****

Physician Signature:_____ Date: _____