

## **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 <u>www.uhccommunityplan.com</u> for medication fax request forms.)

Detient lafe we etien						
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	e):			
<b>Physician Signature</b> **: 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 S	Self-Administer?	Yes No				
Is this medication a New Start?		Yes No				
If <b>NO</b> please provide the following:	Initiation Date: / /	Date of Last Do	ose: / /			
**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						
<ul> <li>Note: Delivery coordination requires a "Physician Signature" above <u>and</u> complete "Provider Information" <u>and</u> "Patient Information"</li> <li>Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery</li> </ul>						
Ship to: Physician's Office  Patient's Address  Date medication is needed: / /						
Medication Administered: Home Health	] Self Administered 🔲 LTC	C 🔲 Physician's Off	ice			
PAGE 1 of 2						

This electronic fax transmission, including any attachments contains information for or from UnitedHealthcare that may be confidential and/or privileged. The information contained in this facsimile is intended to be for the sole use of the individual(s) or entity named above. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this information is strictly prohibited by law and will be vigorously prosecuted. If you have received this electronic fax transmission in error, please notify the sender immediately and destroy all electronic hard copies of the communications including attachments Specialty Med Fax Cover Letter\_C&S\_9.11



Avonex / Rebif / Copaxone PRIOR AUTHORIZATION REQUEST FORM

Community Plan

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

Today's Date							
SECTION A - PATIENT INF	ORMATION						
	First Name: Last Name:		M	ember ID:			
Address:		<u></u>					
	City: State:			Zip:			
Phone:		DOB:		Allergies:			
Primary Insurance:		Policy #:		Group #:			
Is the requested medication	on NEW 🗆 or a	a CONTINUATION of Th	HERAPY⊡? If so, s	start date:			
Is this patient currently ho	spitalized?	Yes □No					
SECTION B - PHYSICIAN	INFORMATION						
First Name:		Last Name:			M.D./D.O.		
Address:		City:	St	ate:	Zip:		
Phone:	Fax:	NPI #:	Sp	pecialty:			
Office Contact Name / Fax A	Attention to:		·				
SECTION C - MEDICAL IN Medication:	FORMATION						
Directions for use:							
Diagnosis (Please be specific & provide as much information as possible):		le):	ICD-10 CODE:				
Does this patient have a diagnosis of relapsing forms of multiple sclerosis? (Check response)							
Did the patient have a first clinical episode with MRI features consistent with multiple sclerosis? (Check response) $\Box$ YES $\Box$ NO							
Additional Clinical Information:							

Physician Signature:

Date:

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.