

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:	Zip:					
Suite Number:	Building Number:						
Phone Number:	Fax number:						
Provider's Specialty:							
Medication Information							
Medication:	Quantity:	ICD-10 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	e: / /				
**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 <u>and</u> complete "Provider Information" <u>and</u> "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 Offic	e 🗆				
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Specialty Med Fax Cover Letter_C&S_9.11



Avonex / Rebif / Copaxone PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date							
SECTION A - PATIENT INFORMATION		Lock Mouse			Mambar ID:		
First Name:		Lasi Name	Last Name:			Member ID:	
Address:		Ctata		T	7:n.		
City: State:				Zip:			
Phone: DOB:					Allergies:		
Primary Insurance: Police		Policy #:	Policy #:		Group #:		
Is the requested medication	on NEW 🗆 or	a CONTINI	UATION of THE	RAPY□? If so	, start date:		
Is this patient currently ho	spitalized?	Yes □N	No				
SECTION B - PHYSICIAN							
First Name:		Last Name:			M.D./D.O.		
Address:			City:		State:	Zip:	
Phone:	Fax:		NPI #:		Specialty:		
Office Contact Name / Fax A	Attention to:						
SECTION C - MEDICAL IN	FORMATION						
Medication:							
Directions for use:							
Diagnosis (Please be specific & provide as much information as possible):				:	ICD-10 CODE:		
Does this patient have a diagnosis of relapsing forms of multiple sclerosis? (Check response) □ YES □ NO Did the patient have a first clinical episode with MRI features consistent with multiple sclerosis? (Check response) □ YES □ NO							
Additional Clinical Information:							
Physician Signature:			_ Date: _				

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Phone: 800-310-6826 Fax: 866-940-7328 Website: www.uhccommunityplan.com