Specialty Med Fax Cover Letter_C&S_12.13



Specialty Medication Prior Authorization Cover Sheet FAX BACK TO: (866) 940-7328 PHONE: (800) 310-6826

(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 Se	If-Administer?	☐Yes ☐No			
Is this medication a New Start?		□Yes □No			
If NO please provide the following:	Initiation Date: / /	Date of Last Dos	e: / /		
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 Ad	ddress	needed: / /			
Medication Administered: Home Health	Self Administered LTC [☐ Physician's Offic	ce 🗆		
SPECIALTY P	RODUCT REQUEST COVER S	HEET			

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



Lupron / Leuprolide

PRIOR AUTHORIZATION REQUEST FORM Page 1 of 2

Complete BOTH PAGES of this form and Fax to: 866-940-7328

Today's Date					
	EODINATION				
First Name:	ECTION A - PATIENT INFORMATION irst Name: Last Name:		Member ID:	lember ID:	
Address:					
	Otata		7:		
City: State:			Zip:	·	
Phone:	DOB:		Allergies:	Allergies:	
Primary Insurance:	Policy #:		Group #:	Group #:	
Is the requested medication	on NEW □ or a CONTIN	IUATION of THERAPY□?	If so, start date:		
Is this patient currently he	ospitalized? □Yes □	No			
SECTION B - PHYSICIAN	INFORMATION				
First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	NPI #:	Specialty:	1	
Office Contact Name / Fax	Attention to:				
SECTION C - MEDICAL IN	IFORMATION				
Medication:	IFORMATION				
	IFORMATION				
Medication:		mation as possible):	ICD-10 CO	DE:	
Medication: Directions for use:		mation as possible):	ICD-10 CO	DE:	
Medication: Directions for use: Diagnosis (Please be specified by the second	cific & provide as much infor				
Medication: Directions for use: Diagnosis (Please be specified by the patient have a his	cific & provide as much infor triosis: story of failure, contraindica	tion, or intolerance to both NAS	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please the patient have a please the patient have a his NO If yes, please the patient have	triosis: story of failure, contraindica	tion, or intolerance to both NAS dates of trial, and reason for dis	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be specified by the patient have a his	cific & provide as much infor triosis: story of failure, contraindica	tion, or intolerance to both NAS	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please the patient have a please the patient have a his NO If yes, please the patient have	triosis: story of failure, contraindica	tion, or intolerance to both NAS dates of trial, and reason for dis	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please the patient have a please the patient have a his NO If yes, please the patient have	triosis: story of failure, contraindica	tion, or intolerance to both NAS dates of trial, and reason for dis	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his pressure of the patient have a his patient have a his pressure of the patient has been patient have a his patient have a his p	triosis: story of failure, contraindica	tion, or intolerance to both NAS dates of trial, and reason for dis	SAIDS and Oral Contra		
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please t	triosis: story of failure, contraindica ase list medication names, o	tion, or intolerance to both NAS dates of trial, and reason for dis	SAIDS and Oral Contra scontinuing:	aceptives?	
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please t	triosis: story of failure, contraindica ase list medication names, of Dates of Therapy Have the patient's sympters	tion, or intolerance to both NAS dates of trial, and reason for dis Reason for Discontinuing oms recurred after one course	SAIDS and Oral Contra scontinuing:	aceptives?	
Medication: Directions for use: Diagnosis (Please be special particular of the patient have a his NO If yes, please t	triosis: story of failure, contraindica ase list medication names, o Dates of Therapy Therapy Therapy Therapy Therapy Therapy Therapy Therapy	tion, or intolerance to both NAS dates of trial, and reason for dis Reason for Discontinuing oms recurred after one course	SAIDS and Oral Contra scontinuing:	aceptives?	
Medication: Directions for use: Diagnosis (Please be specified in the sp	triosis: story of failure, contraindica ase list medication names, of the patient's sympton be used in combination ily	tion, or intolerance to both NAS dates of trial, and reason for dis Reason for Discontinuing oms recurred after one course	SAIDS and Oral Contrascontinuing: of leuprolide? YES	aceptives?	

Lupron / Leuprolide

PRIOR AUTHORIZATION REQUEST FORM Page 2 of 2

For Prostate Cancer:
Does this patient have a diagnosis of prostate cancer? YES NO
For Continuation of therapy: Does the patient show evidence of progressive disease while on therapy? YES NO
For Uterine Leiomyomata (Fibroids): Will leuprolide therapy be used for the reduction of the size of fibroids or for the treatment of anemia? Reduction of the size of fibroids Anemia Will leuprolide be used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure? YES NO
Is this patient's anemia caused by uterine leiomyomata (fibroids)? YES NO
Did the patient respond to iron therapy that was at least 1 month in duration? YES NO
Will leuprolide be used prior to surgery? YES NO
For Central Precocious Puberty:
Female Patients: Did the patient have onset of sexual characteristics when less than 8 years of age? YES NO
Male Patients: Did the patient have onset of sexual characteristics when less than 9 years of age? YES NO
Was the patient's diagnosis defined by one of the following?
A pubertal response to a GnRH stimulation test
Bone age advanced one year beyond chronological age
Other: (please specify)
For continuation of therapy: Must submit documentation of bone age monitoring for consideration of reauthorization.
Additional Clinical Information to support this request:
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.