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: 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 ☐

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

UnitedHealthcare Community Plan

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 9 Code:**

This section MUST be completed for ALL patients with Hepatitis C

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

Genotype (*MUST 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):____

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.

UnitedHealthcare Community Plan

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 in the last 90 days? ◻ YES ◻ NO ***MUST SUBMIT RESULTS***
Must 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 MUST 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? (Must 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? (*Must 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, must 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: ______________

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.