

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.uhcprovider.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ Provider ID Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information

Medication: _____ Quantity: _____ ICD10 Code: _____

Directions: _____ Diagnosis: _____ Refills: _____

Physician Signature:** _____ Initial here if DAW: _____

*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 continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? Yes No

****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

Hepatitis C Medications – Pennsylvania CHIP Only PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____
 Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:

Office Contact Name / Fax attention to: _____

Section C - Medical Information *(This form is for Hepatitis C Medications only; for all other drugs please submit a new form)*

Medication 1:	Strength:
Directions for use:	Quantity:
Medication 2:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

Is this member pregnant? Yes No If yes, what is this member's due date? _____

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 Genotype 5 Genotype 6
 Other Genotype (Must Specify): _____

Has the patient been treated for Hepatitis C previously? Yes No
 If "Yes", please provide details of previous therapy including names of medications used, dates of therapy, and outcome of treatment / reason for discontinuing: _____

Section D – Previous Medication Trials

Trial	Regimen <i>(List all medications tried with each trial)</i>	Dates of Therapy	Treatment Complete	Outcome of Treatment or Reason for Discontinuation
1				
2				
3				
4				

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Member First name:	Member Last name:	Member DOB:
MAVYRET		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient treatment-experienced (previously treated) with any of the following? <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <input type="checkbox"/> An NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor <input type="checkbox"/> An NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor <input type="checkbox"/> Interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor <input type="checkbox"/> Other (please specify): _____ 	
SOVALDI		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of intolerance or contraindication to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <ul style="list-style-type: none"> <input type="checkbox"/> Mavyret <input type="checkbox"/> Sofosbuvir/velpatasvir (the authorized generic of Eplclusa) <input type="checkbox"/> Zepatier 	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient treatment-experienced (previously treated) with an interferon based regimen with or without ribavirin?	
VOSEVI		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of intolerance or contraindication to Mavyret? <i>(If yes, complete Section D above)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been previously treated with a NS3/4A inhibitor?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does any of the following apply to the patient? <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <input type="checkbox"/> Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor. <input type="checkbox"/> Genotype 2, 3, 4, 5, or 6, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor. <input type="checkbox"/> Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir <u>without</u> an NS5A inhibitor. <input type="checkbox"/> Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir <u>without</u> an NS5A inhibitor. <input type="checkbox"/> Other (please specify): _____ 	
ZEPATIER		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have baseline NS5A polymorphisms?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient treatment-experienced (previously treated) with any of the following? <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <input type="checkbox"/> Peginterferon alfa + ribavirin <input type="checkbox"/> Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor 	

Physician Signature: _____ **Date:** _____

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