

**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](http://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

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 Information:		
Is the requested medication <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient have any of the following diagnoses? (If yes, check which applies)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acromegaly</li> <li><input type="checkbox"/> Meningioma</li> <li><input type="checkbox"/> Neuroendocrine Tumors [e.g. carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI tract, lung, and thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]</li> <li><input type="checkbox"/> Hormone-secreting poorly differentiated (high grade)/large or small cell neuroendocrine tumor</li> <li><input type="checkbox"/> Thymoma or Thymic Carcinoma</li> <li><input type="checkbox"/> Malignant Bowel Obstruction</li> <li><input type="checkbox"/> Diarrhea Due to Concurrent Cancer Chemotherapy and/or Radiation</li> <li><input type="checkbox"/> HIV/AIDS-Related Diarrhea</li> <li><input type="checkbox"/> Bleeding Gastroesophageal Varices associated with liver disease</li> </ul>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Is this for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium?</b></p> <p><i>If yes, List supported use:</i></p>

**ACROMEGALY**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Did the patient experience an inadequate response to any of the following?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Surgery</li> <li><input type="checkbox"/> Radiotherapy</li> <li><input type="checkbox"/> Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul> <p><i>If yes, check which applies and list response:</i></p>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Is the patient NOT a candidate for any of the following?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Surgery</li> <li><input type="checkbox"/> Radiotherapy</li> <li><input type="checkbox"/> Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul> <p><i>If yes, check which applies and list response:</i></p>

**MENINGIOMA**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the disease surgically inaccessible?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have recurrent or progressive disease?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is additional radiation not possible?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the disease octreotide scan positive?</b>

**CONTINUATION OF THERAPY**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient show evidence of progressive disease while on therapy?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of positive clinical response to Sandostatin therapy?</b> <i>If yes, list response:</i>

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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