

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

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 Information:

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

Medication:	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? _____

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 for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
Clinical and Drug Specific Information		
<p>- What is the patient's diagnosis? (check which applies)</p> <p><input type="checkbox"/> Clinically significant euvolemic hyponatremia <input type="checkbox"/> Clinically significant hypervolemic hyponatremia <input type="checkbox"/> Other. List diagnosis: _____</p>		
<p>- Has the patient responded to fluid restriction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A, the patient has not tried fluid restriction If no, list trial dates: _____</p>		
<p>- Has treatment been initiated or re-initiated in a hospital setting prior to discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, List Admission Date: _____ Discharge Date: _____</p>		

Physician Signature: _____ **Date:** _____

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