UnitedHealthcare
Community Plan

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.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 ☐

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UnitedHealthcare Community Plan

Hepatitis C Medications – New Jersey

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 this 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, HCV RNA levels from previous therapy and outcome of treatment / reason for discontinuing: _____________________

____

____

Section D – Previous Medication Trials

Trial	**Regimen (*List all medications tried with each trial)***	**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:

Clinical and Drug Specific Information

ALL REQUESTS

The following information below MUST be included upon submission:

□ Medication name, dose, and duration □ Relevant medical records and laboratory results

Please select one of the following:

□ Compensated cirrhosis (Child-Pugh A) □ Decompensated cirrhosis (Child-Pugh B or C) □ No Cirrhosis

Document the patient's weight: ________ Kg

Duration of treatment: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other: ________ weeks

□ **Yes** □ **No**	**Does the patient have chronic hepatitis C, with labs showing genotype and detectable hepatitis C virus ribonucleic acid (HCV RNA) levels from within the past 90 days?** *If yes, list HCV RNA and date:*
□ **Yes** □ **No**	**Is the patient any of the following?** *(If yes, check which applies)* □ Kidney transplant recipient □ Liver transplant recipient
□ **Yes** □ **No**	**Will the requested medication used in combination with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa □ Ribavirin
□ **Yes** □ **No**	**Is the patient ineligible for any of the following?** *(If yes, check which applies)* □ Interferon □ Ribavirin
□ **Yes** □ **No**	**If the patient has severe renal impairment (including CrCl < 30 mL/min or ESRD), is the urgency to treat high and renal transplant is not an immediate option?**
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies)* □ Contraindications to requested hepatitis C therapy □ Patient is on any therapies identified by the prescribing information or AASLD/IDSA guidelines as therapies not recommended for co-administration □ Limited life expectancy
□ **Yes** □ **No**	**If patient is ribavirin intolerant/ineligible, will documentation (including a copy of lab work from within the past 30 days if applicable) of any of the following, be submitted?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient has a contraindication to ribavirin □ Patient is on therapy identified by the prescribing information or AASLD/IDSA guidelines as therapies not recommended for co-administration □ Patient has hemoglobin levels that preclude use of ribavirin □ Patient previously had a side effect or allergic reaction to ribavirin therapy
□ **Yes** □ **No**	**If requested medication is combined with ribavirin, does the patient meet any of the following?** *(If yes, check which applies)* □ Patient has no contraindication to ribavirin □ Neither the patient nor the partner of the patient is pregnant □ If patient or their partner is of child bearing age, the patient has been or will be instructed to practice effective contraception during therapy and for 6 months after stopping ribavirin therapy
□ **Yes** □ **No**	**For regimens that depend on testing [e.g., baseline high fold-change NS5A RASs (includes G1a polymorphisms at amino acid positions 28, 30, 31, or 93), baseline Q80K polymorphism, Y93H mutation], is a copy of the lab work attached?** *DOCUMENTATION REQUIRED*

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Member First name:	Member Last name:	Member DOB:

EPCLUSA	
☐ Yes ☐ No	**If request is for brand Epclusa, is there an explanation of medical necessity for brand versus the authorized generic?** *If yes, provide explanation:*
HARVONI OR LEDIPASVIR/SOFOSBUVIR (AUTHORIZED GENERIC OF HARVONI)	
☐ Yes ☐ No	**Does the patient have a history of intolerance or contraindication to any of the following?** *(If yes, check which applies and complete Section D above)* ☐ Mavyret ☐ Sofosbuvir/velpatasvir (the authorized generic of Epclusa) ☐ Zepatier
☐ Yes ☐ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies)* ☐ Peginterferon alfa + ribavirin based regimen with or without an HCV protease inhibitor ☐ Interferon based regimen with or without ribavirin
☐ Yes ☐ No	**If request is for brand Harvoni, is there an explanation of medical necessity for brand versus the authorized generic?** *If yes, provide explanation:*
MAVYRET	
☐ Yes ☐ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies)* ☐ An NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor ☐ An NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor ☐ Interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor ☐ Other (please specify): ______________________________
SOVALDI	
☐ Yes ☐ No	**Does the patient have a history of intolerance or contraindication to any of the following?** *(If yes, check which applies and complete Section D above)* ☐ Mavyret ☐ Sofosbuvir/velpatasvir (the authorized generic of Epclusa) ☐ Zepatier
☐ Yes ☐ No	**Does the patient have hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first?**
☐ Yes ☐ No	**Is the patient treatment-experienced (previously treated) with interferon based regimen with or without ribavirin?**
VOSEVI	
☐ Yes ☐ No	**Does the patient have a history of intolerance or contraindication to Mavyret?** *(If yes, complete Section D above)*
☐ Yes ☐ No	**Has the patient been previously treated with a NS3/4A inhibitor?**
☐ Yes ☐ No	**Does any of the following apply to the patient?** *(If yes, check which applies)* ☐ Genotype 1 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor. ☐ 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. ☐ Genotype 1a, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor. ☐ Genotype 3, and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor. ☐ Other (please specify): ______________________________

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ZEPATIER	
□ Yes □ No	**Does the patient have baseline NS5A polymorphisms?**
□ Yes □ No	**Is the patient treatment-experienced (previously treated) with any of the following?** *(If yes, check which applies)* □ Peginterferon alfa + ribavirin □ Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor

Physician Signature: ____ **Date:** ____________________

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