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 ☐

UnitedHealthcare Community Plan

Humira – New York EPP

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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Active psoriatic arthritis □ Ankylosing spondylitis □ Moderate to severe chronic plaque psoriasis □ Moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III) □ Moderately to severely active Crohn's disease □ Moderately to severely active polyarticular juvenile idiopathic arthritis □ Moderately to severely active rheumatoid arthritis (RA) □ Moderately to severely active ulcerative colitis □ Non-infectious uveitis (UV)
□ **Yes** □ **No**	**Will the patient receive Humira in combination with any of the following?** *(if yes, check which applies_* □ Biologic DMARD [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab)] □ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)] □ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]
□ **Yes** □ **No**	**Does the patient have history of failure to a 3-month trial of methotrexate at up to the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
	ANKYLOSING SPONDYLITIS
□ **Yes** □ **No**	**Does the patient have a history of failure to two NSAIDs (non-steroidal anti-inflammatory drugs) [e.g., ibuprofen, naproxen] at up to maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
	CROHN'S DISEASE
□ **Yes** □ **No**	**Does the patient have a history of failure to any of the following conventional therapies at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, check which applies and complete Section D above)* □ 6-mercaptopurine (Purinethol) □ Azathioprine (Imuran) □ Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) □ Methotrexate (Rheumatrex, Trexall)
□ **Yes** □ **No**	**Has the patient lost response or is intolerant to infliximab (e.g., Remicade, Inflectra, Renflexis)?** *(If yes, complete Section D above)*
	HIDRADENITIS SUPPURATIVA
□ **Yes** □ **No**	**Does the patient have a history of failure to at least one oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
	PLAQUE PSORIASIS
□ **Yes** □ **No**	**Does the patient have greater than or equal to 5% body surface area (BSA) involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis?**
□ **Yes** □ **No**	**Does the patient have history of failure to any of the following topical therapies within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, check which applies and complete Section D above)* □ Anthralin □ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) □ Coal tar □ Corticosteroids (e.g., betamethasone, clobetasol, desonide) □ Tazarotene □ Vitamin D analogs (e.g., calcitriol, calcipotriene)

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Member First name:	Member Last name:	Member DOB:

	RHEUMATOID ARTHRITIS (RA)
□ **Yes** □ **No**	**Does the patient have a history of failure to a 3 month trial of any non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at up to maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
	ULCERATIVE COLITIS
□ **Yes** □ **No**	**Does the patient have a history of failure to any of the following conventional therapies at up to maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, check which applies and complete Section D above)* □ 6-mercaptopurine (Purinethol) □ Azathioprine (Imuran) □ Corticosteroids (e.g., prednisone, methylprednisolone, budesonide) □ Methotrexate (Rheumatrex, Trexall)
	UVEITIS (UV)
□ **Yes** □ **No**	**Is the patient's diagnosis classified as any of the following?** *(If yes, check which applies)* □ Intermediate □ Panuveitis □ Posterior
□ **Yes** □ **No**	**Does the patient have a history of failure to at least one corticosteroid (e.g., prednisolone, prednisone) at up to a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a history of failure to at least one systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at up to a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced?** *(If yes, complete Section D above)*
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Does the patient have a documented positive clinical response to Humira therapy?** *If yes, list response:*

Physician Signature: _____ **Date:** _____