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

Hepatitis C Medications – Rhode Island
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, 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 with current medication list
□ Laboratory results dated within the last 90 days □ Agreement to submit post-treatment viral load data if requested

Please select one of the following:
□ Compensated cirrhosis (Child-Pugh A) □ Decompensated cirrhosis (Child-Pugh B or C) □ No Cirrhosis

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

Document the patient's quantitative viral load and date of testing (date of testing must be within 90 days of request:
Quantitative viral load: _____ *Date of testing:* _____

□ **Yes** □ **No**	**Is this a continuation of treatment when transitioning between publicly funded delivery systems (e.g., between fee for service Medicaid and managed care Medicaid, between managed care Medicaid and fee for service Medicaid, or between the department of corrections and the Medicaid program)?**
□ **Yes** □ **No**	**Does the patient have documented chronic hepatitis C, stage 0 through 4, including the test used to determine disease stage?** *If yes, list disease stage and test used to determine disease stage:*
□ **Yes** □ **No**	**Is the patient managed by a provider on the Rhode Island Medicaid Hepatitis C Preferred Provider List who either assumes direct responsibility for care or who, after consultation and establishing a treatment plan, co-manages the patient with the primary care provider?**
□ **Yes** □ **No**	**For patients with decompensated cirrhosis, was the patient referred to a physician with experience in managing such disease (ideally at a center with liver transplant capabilities)?**
□ **Yes** □ **No**	**Is the patient any of the following?** *(If yes, check which applies)* □ Liver transplant recipient □ Kidney transplant recipient

MAVYRET

□ **Yes** □ **No**	**Does the patient have one of the following?** *(If yes, check which applies)* □ Genotype 1, 2, 3, 4, 5, or 6 and treatment naïve □ Genotype 1 and treatment-experienced (previously treated) with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor □ Genotype 1 and treatment-experienced (previously treated) with an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor □ Genotype 1, 2, 3, 4, 5, or 6 and treatment-experienced (previously treated) with interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor

VOSEVI

□ **Yes** □ **No**	**Does the 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
□ **Yes** □ **No**	**Has the patient been previously treated with an NS3/4A inhibitor?**
□ **Yes** □ **No**	**Does the patient have a history of intolerance or contraindication to Mavyret?** *(If yes, complete Section D above)*

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NON-PREFERRED AGENTS	
□ Yes □ No	**Is the patient completing a cycle therapy which was initiated prior to current policy implementation?**
□ Yes □ No	**Is there detailed clinical documentation of the need for an alternative, non-preferred agent?** *If yes, provide documentation:*

Physician Signature: _____ Date: _____