

**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

## Hematopoietic Agents-Granulocyte Colony Stimulating Factors- Washington

### 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 <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

## Hematopoietic Agents-Granulocyte Colony Stimulating Factors- Washington

PRIOR AUTHORIZATION REQUEST FORM

|  |  |             |
|--|--|-------------|
| Member First name:                                       | Member Last name:  | Member DOB: |
| <b>Clinical and Drug Specific Information</b>            |  |             |
| <b>ALL REQUESTS</b>                                      |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does any of the following apply to the patient?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> Receiving induction and/or consolidation chemotherapy for acute myeloid leukemia (AML)<br><input type="checkbox"/> Primary prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy<br><input type="checkbox"/> Secondary prevention of febrile neutropenia in patients receiving myelosuppressive chemotherapy<br><input type="checkbox"/> Treatment of febrile neutropenia<br><input type="checkbox"/> Diagnosis of cancer and undergoing bone marrow transplantation<br><input type="checkbox"/> Undergoing autologous peripheral blood progenitor cell collection and therapy<br><input type="checkbox"/> Severe chronic neutropenia<br><input type="checkbox"/> Hematopoietic sub syndrome of acute radiation syndrome |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does the patient have an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least two preferred agents?</b> <i>(If yes, complete Section D above)</i>   |             |
| <b>PRIMARY PREVENTION OF FEBRILE NEUTROPENIA</b>         |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does the chemotherapy regimen have a greater than 20 percent risk for febrile neutropenia?</b>  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does the chemotherapy regimen have a 10 to 20 percent risk for febrile neutropenia?</b>   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does the patient meet any of the following?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> Extensive prior chemotherapy or radiation therapy to pelvis or other areas important for bone marrow reserve<br><input type="checkbox"/> Persistent neutropenia (ANC 1000/mm <sup>3</sup> or less)<br><input type="checkbox"/> Bone marrow involvement by tumor<br><input type="checkbox"/> Recent surgery and/or open wounds<br><input type="checkbox"/> Liver dysfunction (bilirubin > 2.0 mg/dL)<br><input type="checkbox"/> Renal dysfunction (eGFR < 50 mL/min/1.73m <sup>2</sup> )<br><input type="checkbox"/> Age > 65 years and receiving full chemotherapy dose intensity<br><input type="checkbox"/> Poor performance status   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Has the patient experienced treatment delay of curative chemotherapy due to a dose-limiting neutropenic event, with the same dose and schedule planned for future cycles?</b>   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Is there documentation of treatment failure or a clearly stated rational of an inability to complete course of treatment (e.g. patient is unable to administer daily injections, patient is a young child, etc.) with a preferred short-acting G-CSF?</b> <i>(If yes, complete Section D above)</i>   |             |
| <b>SECONDARY PREVENTION OF FEBRILE NEUTROPENIA</b>       |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Has the patient experienced febrile neutropenia with a previous cycle of similar chemotherapy, with the same dose and schedule planned for future cycles?</b>   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Has the patient experienced treatment delay of curative chemotherapy due to a dose-limiting neutropenic event, with the same dose and schedule planned for future cycles?</b>   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Has the patient experienced treatment delay of palliative chemotherapy due to a dose-limiting neutropenic event, and dose reduction or a delay in frequency of subsequent chemotherapy cycles is not recommended?</b>   |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Is there documentation of treatment failure or a clearly stated rational of an inability to complete course of treatment (e.g. patient is unable to administer daily injections, patient is a young child, etc.) with a preferred short-acting G-CSF?</b> <i>(If yes, complete Section D above)</i>   |             |

## Hematopoietic Agents-Granulocyte Colony Stimulating Factors- Washington

PRIOR AUTHORIZATION REQUEST FORM

|  |   |                    |
|--|---|--------------------|
| <b>Member First name:</b>  | <b>Member Last name:</b>  | <b>Member DOB:</b> |
| <b>TREATMENT OF FEBRILE NEUTROPENIA</b>  |   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Does the patient have one any of the following high-risk factors?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> Age greater than 65 years<br><input type="checkbox"/> Hospitalized for febrile neutropenia<br><input type="checkbox"/> Sepsis syndrome<br><input type="checkbox"/> Invasive fungal infection<br><input type="checkbox"/> Clinically documented infection such as pneumonia<br><input type="checkbox"/> Prolonged or profound neutropenia<br><input type="checkbox"/> History of prior episodes of febrile neutropenia |                    |
| <b>WITH CANCER UNDERGOING BONE MARROW TRANSPLANTATION</b>                            |   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Is Filgrastim administered at least 24 hours after any of the following?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> Cytotoxic chemotherapy<br><input type="checkbox"/> Bone marrow infusion  |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Are CBC &amp; platelet counts monitored daily during neutrophil recovery?</b>  |                    |
| <b>UNDERGOING AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL COLLECTION AND THERAPY</b> |   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Is Filgrastim administered for at least 4 days before the first leukapheresis procedure?</b>   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Is Filgrastim continued until the last leukapheresis?</b>  |                    |
| <b>SEVERE CHRONIC NEUTROPENIA (SCN)</b>  |   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Has the diagnosis been confirmed by evaluating serial CBCs with differential and platelet counts, and evaluating bone marrow morphology and karyotype?</b>   |                    |
| <b>ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION</b>                        |   |                    |
| <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>               | <b>Has the patient been exposed to lethal doses of total-body radiation, but not doses high enough to lead to certain death as a result of injury to other organs?</b>  |                    |

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

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