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

Multiple Sclerosis - Ocrevus

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

UnitedHealthcare Community Plan

Multiple Sclerosis - Ocrevus

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ Yes □ No	**Does any of the following apply to the patient?** *(If yes, check which applies)* □ Relapsing Remitting Multiple Sclerosis (RRMS) □ Primary Progressive Multiple Sclerosis (PPMS)
	RELAPSING REMITTING MULTIPLE SCLEROSIS (RRMS)
□ Yes □ No	**Has an appropriate wash-out period elapsed prior to planned treatment with Ocrevus (ocrelizumab)?**
□ Yes □ No	**Was the patient previously treated with disease-modifying drugs with long lasting treatment effects (e.g., natalizumab, alemtuzumab)?**
□ Yes □ No	**Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?**
□ Yes □ No	**Does the patient have negative test results for hepatitis B viral infection?**
□ Yes □ No	**Is the patient's Expanded Disability Status Scale (EDSS) 6.5 or greater?**
□ Yes □ No	**Does the patient have imaging evidence of active disease?**
□ Yes □ No	**Does the patient have at least ONE documented relapsing event in the last 2 years?** *If yes, list:*
□ Yes □ No	**Is there documentation that the provider has discussed the benefits and risks of continuing disease-modifying therapy?**
□ Yes □ No	**Did the patient have an inadequate response to two or more medications FDA-approved for the same indication and/or medications that are considered the standard of care?** *(If yes, complete Section D above)*
	PRIMARY PROGRESSIVE MULTIPLE SCLEROSIS (PPMS)
□ Yes □ No	**Does the patient have a diagnosis of PPMS according to the revised McDonald Criteria?**
□ Yes □ No	**Does the patient have documented oligoclonal IgG bands in cerebral spinal fluid?**
	Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?
□ Yes □ No	**Does the patient have T2 lesions on brain or spinal cord imaging?**
□ Yes □ No	**Is the patient in the ambulatory stage of disease [EDSS (Expanded Disability Status Scale) < 7]?**
□ Yes □ No	**Is the patient concurrently taking other disease-modifying therapies for multiple sclerosis (MS)?**
	CONTINUATION OF THERAPY
□ Yes □ No	**Does the patient have a documented clinical benefit to therapy, as determined by the prescriber?** *If yes, list response:*

Physician Signature: _____ **Date:** _____