

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

Gonadotropin-Releasing Hormone (GnRH) Agonists

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

Member First name:	Member Last name:	Member DOB:
--------------------	-------------------	-------------

Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Adjunct for gender-affirming hormonal therapy for transgender adults <input type="checkbox"/> Advanced or metastatic prostate cancer <input type="checkbox"/> Central precocious puberty (idiopathic or neurogenic) <input type="checkbox"/> Endometriosis or endometriosis is suspected <input type="checkbox"/> Fertility preservation <input type="checkbox"/> Gender dysphoria in adolescents <input type="checkbox"/> Uterine leiomyomata (fibroids)
--	---

ADJUNCT FOR GENDER-AFFIRMING HORMONAL THERAPY FOR TRANSGENDER ADULTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have the patient's gonads (i.e., testes, ovaries) been removed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's gonads functional (e.g., hormone producing)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there an inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i> <ul style="list-style-type: none"> Transgender patient has identified goals of gender-affirming hormone therapy Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed Current enrollment, attendance, and active participation in psychological and social support treatment program Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

CENTRAL PRECOCIOUS PUBERTY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the onset of secondary sexual characteristics occur in the patient at one of the following ages? <i>(If yes, check which applies)</i> <input type="checkbox"/> ≤ 8 years of age in females <input type="checkbox"/> ≤ 9 years of age in males
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the diagnosis confirmed by any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> A pubertal luteinizing hormone response to a GnRH stimulation test <input type="checkbox"/> Bone age advanced one year beyond the chronological age <input type="checkbox"/> Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)
<input type="checkbox"/> Yes <input type="checkbox"/> No	For <u>Triptodur requests</u>, does the patient have a history of failure, contraindication, or intolerance to Lupron-Depot Ped? <i>(If yes, complete Section D above)</i>

ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Non-steroidal anti-inflammatory drugs (NSAIDs) <input type="checkbox"/> Oral contraceptives or depot medroxyprogesterone (e.g., Depo- Provera)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had surgical ablation to prevent recurrence?
<input type="checkbox"/> Yes <input type="checkbox"/> No	For <u>Lupaneta Pack requests</u>, does the patient have a history of failure, contraindication, or intolerance to Lupron Depot? <i>(If yes, complete Section D above)</i>

Gonadotropin-Releasing Hormone (GnRH) Agonists

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:
FERTILITY PRESERVATION		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication for use in a pre-menopausal woman?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]?	
GENDER DYSPHORIA IN ADOLESCENTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced puberty development to at least Tanner stage 2?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have laboratory tests, based upon the laboratory reference range, confirming any of the following? (If yes, check which applies) <input type="checkbox"/> Pubertal levels of estradiol in females <input type="checkbox"/> Pubertal levels of testosterone in males <input type="checkbox"/> Pubertal basal level of luteinizing hormone (based on laboratory reference ranges) <input type="checkbox"/> A pubertal luteinizing hormone response to a GnRH stimulation test	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? (If yes, please submit letter and/or documentation along with this fax) <ul style="list-style-type: none"> Patient has experienced pubertal changes that have resulted in an increase of their gender dysphoria that has significantly impaired psychological or social functioning Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed Current enrollment, attendance, and active participation in psychological and social support treatment program Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 	
UTERINE LEIOMYOMATA (FIBROIDS)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this request for the treatment of uterine leiomyomata-related anemia?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient respond to 1 month of iron therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used prior to surgery?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)?	
CONTINUATION OF THERAPY - ADJUNCT FOR GENDER-AFFIRMING HORMONAL THERAPY FOR TRANSGENDER ADULTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a change in dosing?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are the patient's gonads (i.e., testes, ovaries) intact?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? (If yes, please submit letter and/or documentation along with this fax) <ul style="list-style-type: none"> Transgender patient continues to meet goals of gender-affirming hormone therapy Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment continue to be addressed or removed Current enrollment, attendance, and active participation in psychological and social support treatment program Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 	

Gonadotropin-Releasing Hormone (GnRH) Agonists

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:
CONTINUATION OF THERAPY – ADVANCED OR METASTATIC PROSTATE CANCER		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient show evidence of progressive disease with on therapy?	
CONTINUATION OF THERAPY - CENTRAL PRECOCIOUS PUBERTY (CPP)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving therapy for central precocious puberty?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of positive clinical response to therapy?	
CONTINUATION OF THERAPY - ENDOMETRIOSIS OR ENDOMETRIOSIS IS SUSPECTED		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced a recurrence of symptoms following an initial course of therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used concurrently with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)? <i>If yes, list add-back therapy:</i>	
CONTINUATION OF THERAPY - FERTILITY PRESERVATION		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving GnRH analog therapy for the purpose of fertility preservation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient continue to receive a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]?	
CONTINUATION OF THERAPY - GENDER DYSPHORIA IN ADOLESCENTS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a change in dosing?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will a letter from the prescriber and/or formal documentation stating ALL of the following be submitted? <i>(If yes, please submit letter and/or documentation along with this fax)</i> <ul style="list-style-type: none"> Patient continues to meet their individual goals of therapy for gender dysphoria Patient continues to have a strong affinity for the desired (opposite of natal) gender Discontinuation of treatment and subsequent pubertal development would interfere with or impair psychological functioning and well-being Coexisting psychiatric and medical comorbidities or social problems that may interfere with treatment continue to be addressed or removed Current enrollment, attendance, and active participation in psychological and social support treatment program Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies 	

Physician Signature: _____ **Date:** _____

Confidentiality Notice: This transmission contains confidential information belonging to the sender and United HealthCare. This information is intended only for the use of United HealthCare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.