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 ☐

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UnitedHealthcare Community Plan

# Xolair - Nebraska

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 for a list of preferred alternatives**

UnitedHealthcare Community Plan

**Xolair - Nebraska**

PRIOR AUTHORIZATION REQUEST FORM

| 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)*<br>□ Moderate or Severe Asthma<br>□ Chronic Idiopathic Urticaria |
| □ Yes □ No | **Is Xolair prescribed by or in consultation with one of the following specialist?**<br>□ Allergist/immunologist □ Pulmonologist □ Dermatologist |

### MODERATE OR SEVERE ASTHMA

| | |
| --- | --- |
| □ Yes □ No | **Is the patient's asthma classified as uncontrolled or inadequately controlled as defined by at least one of the following?** *(If yes, check which applies)*<br>□ Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)<br>□ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months<br>□ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)<br>□ Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])<br>□ Patient is currently dependent on oral corticosteroids for the treatment of asthma |
| □ Yes □ No | **Is the patient's baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1500 IU/mL?**<br>*If yes, List results: _________ IU/mL* |
| □ Yes □ No | **Did the patient have a positive skin test or in vitro reactivity to a perennial aeroallergen?** |
| □ Yes □ No | **Will the patient use Xolair with one maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2-agonist (LABA) product [e.g., fluticasone propionate/salmeterol (Advair), budesonide/formoterol (Symbicort)]?**<br>*If yes, list medication:* |
| □ Yes □ No | **Will the patient use Xolair with combination therapy including <u>both</u> of the following:**<br>□ One high-dose (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone zuroate (Asmanex), beclomethasone dipropionate (QVAR)]<br>□ One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]<br>*List combination therapy:* |
| □ Yes □ No | **Will the patient receive Xolair in combination with <u>any</u> of the following?** *(If yes, check which applies)*<br>□ Anti-interleukin 4 therapy [e.g. Dupixent (dupilumab)]<br>□ Anti-interleukin 5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] |

### CHRONIC URTICARIA

| | |
| --- | --- |
| □ Yes □ No | **Does the patient remain symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to, <u>two</u> H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]?**<br>*(If yes, complete Section D above)* |
| □ Yes □ No | **Does the patient remain symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to <u>both</u> of the following taken in combination?**<br>*(If yes, check which applies and complete Section D above)*<br>□ Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]<br>□ One of the following:<br>- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]<br>- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]<br>- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]<br>- Leukotriene modifier [e.g., Singulair (montelukast)] |

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PRIOR AUTHORIZATION REQUEST FORM

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

| | |
|---|---|
| **CONTINUATION OF THERAPY - ASTHMA** | |
| □ Yes □ No | **Does the patient have a documentation of positive clinical response as demonstrated by at least one of the following: reduction in frequency of exacerbations, decreased utilization of rescue medications, increase in percent predicted FEV1 from pretreatment baseline, reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing)?** *If yes, list response:* |
| □ Yes □ No | **Is the patient using Xolair in combination with an ICS-containing controller medication?** *If yes, list medication:* |
| □ Yes □ No | **Is the patient receiving Xolair in combination with any of the following?** *(If yes, check which applies)* □ Anti-interleukin 4 therapy [e.g. Dupixent (dupilumab)] □ Anti-interleukin 5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)] |
| **CONTINUATION OF THERAPY – CHRONIC URTICARIA** | |
| □ Yes □ No | **Does the patient have a documented positive clinical response (e.g., reduction in exacerbations, itch severity, hives) to Xolair therapy?** *If yes, list response:* |

**Physician Signature:** ______________________________________________ **Date:** ___________________

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