United Healthcare Community Plan

Cytokine & CAM Antagonists - 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 may contain 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 (if any):		

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

Medication Name	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

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Member First Name	Member Last Name	Member DOB

1. Is client currently stable on therapy? ☐ Yes ☐ No
   If yes, is there documentation of positive clinical response? ☐ Yes ☐ No

2. What is patient's current weight? __________ kg Date taken: __________

3. Indicate patient's diagnosis:
   ☐ Ankylosing Spondylitis (AS)
   ☐ Crohn's Disease (CD)
   ☐ Hidradenitis Suppurativa (HS)
   ☐ Juvenile Idiopathic Arthritis (JIA)
   ☐ Plaque Psoriasis (Ps)
   ☐ Psoriatic Arthritis (PsA)
   ☐ Rheumatoid Arthritis (RA)
   ☐ Ulcerative Colitis (UC)
   ☐ Non-radiographic axial spondyloarthritis
   ☐ Non-infectious Uveitis (UV) classified as intermediate, posterior or panuveitis
   ☐ Other. Specify: __________

4. Has patient tried and failed, has an intolerance or contraindication to any of the following(check all that apply):
   ☐ Acetretin
   ☐ Corticosteroids
   ☐ Enbrel (etanercept)
   ☐ Humira (adalimumab)
   ☐ mesalamine/budesonide MMX
   ☐ NSAIDs
   ☐ Phototherapy
   ☐ systemic antibiotics
   ☐ topical therapies
   ☐ Non-biologic DMARD(s) (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, 6-mercaptopurine, methotrexate, sulfasalazine)
   ☐ Other. Specify: __________

5. Will patient be taking any of the following in combination with this request (mark all that apply)?
   ☐ Biologic DMARD
   ☐ Phosphodiesterase (PDE 4) inhibitor
   ☐ Janus kinase inhibitor
   ☐ None

6. Does patient have a negative TB test within the last year? ☐ Yes ☐ No

7. Is this prescribed by or in consultation with any of the following (mark all that apply):
   ☐ Dermatologist
   ☐ Gastroenterologist
   ☐ Ophthalmologist
   ☐ Rheumatologist
   ☐ Other. Specify: __________

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

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