UnitedHealthcare Community Plan

Antineoplastics and Adjunctive Therapies
Imidazotetrazines, Oral - 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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response? ☐ Yes ☐ No

2. What is the patient's diagnosis (ICD code plus description)? _____
   Indicate stage: _____
   Indicate disease type (i.e. New onset, refractory, etc.): _____

3. Is this being used in combination with other chemotherapeutic, radiotherapeutic, or adjuvant agents?
   ☐ Yes ☐ No
   If yes, list all therapies: _____

4. List treatments patient has previously tried and dates these treatments were started: _____
   _____

   How long was the patient on these treatments? _____

   Why were they stopped or discontinued? _____

   If agent was stopped for lack of benefit, include documentation of what measures were used to define a positive clinical response and what the change was from baseline.

5. Has the diagnosis and staging been confirmed with either an FDA approved companion diagnostic test, medically necessary test to confirm a gene-mutation or any other companion tests used for concurrent or previous treatments?
   ☐ Yes ☐ No
   Attach labs and results of all diagnostic tests performed to confirm diagnosis.

6. Is there a contraindication to the requested medication or any other medications that are part of the patient's regimen? ☐ Yes ☐ No
   If yes, indicate contraindication(s): _____

7. What is the patient's planned dosing regimen? _____

8. Has this medication been prescribed by, or in consultation with a specialist in oncology or neurology?
   ☐ Yes ☐ No

9. Indicate for patient:
   Height (cm): _____ **Date taken:** _____
   Weight (kg): _____ **Date taken:** _____
   Body surface area (m^2): _____ **Date taken:** _____

CHART NOTES, LABS AND RESULTS OF DIAGNOSTIC TESTS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date