

UPMC HEALTH PLAN

NON-FORMULARY MEDICATIONS

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services. Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE: 1-800-979-UPMC (8762)

FAX: 412-454-7722

PLEASE TYPE OR PRINT NEATLY

*Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc.
Incomplete responses may delay this request.*

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty. Dispensed (# of units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication	If ongoing, please provide date started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:			

Please indicate place of administration:			
<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Hospital/Facility	<input type="checkbox"/> Patient Home	<input type="checkbox"/> Other
Please provide hospital/facility information:		Will the drug be: (select one)	
Name: _____		<input type="checkbox"/> Billed medically using a JCODE	
Phone #: _____		JCODE: _____	
Address: _____		<input type="checkbox"/> Billed at a pharmacy	

HISTORY OF MEDICATIONS USED TO TREAT THE ABOVE CONDITION

(SPECIFIC CLINICAL INFORMATION IS ESSENTIAL TO DETERMINE WHETHER THIS MEDICATION CAN BE APPROVED)

Have other medications been used in the past to treat this condition? Yes No

If yes, please provide the following information for ALL past medications tried:

Medication Name	Start Date	End Date	Strength	Frequency	Reason for failure, discontinuation

Please provide any additional information which should be considered in the space below:
