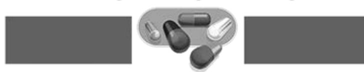


# NON-FORMULARY MEDICATIONS

## 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:** ❑ **Brand** ❑ **Generic** | **Strength:** | **Frequency:** | **Qty. Dispensed (# of units):** |

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

| ❑ New medication ❑ Ongoing medication | **If ongoing, please provide date started:** | **If medication is ongoing, did the member show improvement while on therapy?** | ❑ Yes ❑ No |
|---|---|---|---|

**Diagnosis:**

**Please indicate place of administration:**
❑ Physician's Office ❑ Hospital/Facility ❑ Patient Home ❑ Other

| **Please provide hospital/facility information:**<br>**Name:** ______<br>**Phone #:** ______<br>**Address:** ______<br>______ | **Will the drug be: (select one)**<br>❑ Billed medically using a JCODE<br>JCODE: ______<br>❑ 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:**