## 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:

Please complete all sections of t		PLEASE TY	PE OR P	RIN'				412-45		
using formulary alternat	ives, i.e. past pro	escription treatmen Incomplete resp	ıt failures,	docu	ımented side effects,	chart doci	unentation, lab	values, e	eption to etc.	
Office Contact:				Provider Specialty:						
Provider First Name:			Provider Last Name:							
Provider Phone:	Provider Fax:			Fax:	Provider NPI #:					
Patient Name:		Patient UPMC Health Plan ID Number: Pa				Patie	nt DOB: Patient Age:		ent Age:	
Drug Requested:		Strength:		Frequency:			Qty. Dispensed (# of units)		of units):	
☐ Brand ☐ Generic										
☐ New medication								did the member		
☐ Ongoing medication started: show improvement while on therapy? ☐ No Diagnosis:										
Please indicate place of ad	ministration:	;								
☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home ☐ Other										
Please provide hospital/facility information: Name: Will the drug be: (select one) □ Billed medically using a JCODE										
Name: Phone #:			JCODE:					_		
Address:	☐ 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		nuation		
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Please pr	ovide any add	itional informati	ion which	1 SNO	uld be considered	in the sp	ace below:			