

UPMC HEALTH PLAN

Six Prescription Fill Per Calendar Month Limit

UPMC for You Medical Assistance only

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 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:
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Provider First Name:	Provider Last Name:
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Provider Phone:	Provider Fax:	Provider NPI#:
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Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
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Drug Requested:	Strength:	Frequency:	Qty Dispensed:
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Brand Generic

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

Expected duration of therapy: _____

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

Certain UPMC for You members have limited benefits and are subject to a 6 prescription per calendar month benefit limit. If you feel an exception to this benefit limit is necessary, please complete the following information.

Please indicate diagnosis: _____

Please provide a narrative explaining the immediate medical need for this product:

Please indicate medications used to treat the member's condition/s below:

Medication Trial/Previous Therapy	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing