

# UPMC HEALTH PLAN

## Actimmune

### 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

**THIS SECTION FOR PROVIDER USE ONLY—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.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b>	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	<b>If ongoing, provide date started:</b>	<b>If medication is ongoing, Did the member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	
<b>Place of infusion? (Name and Location)</b> <input type="checkbox"/> Physician's Office:  <input type="checkbox"/> Hospital/Facility:		<b>Will the drug be: (select one)</b> <input type="checkbox"/> Billed directly by the provider via JCODE If billed via JCODE, please provide the name of provider or vendor that will bill for this drug: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

#### Medical History

*Please indicate diagnosis:*

Chronic Granulomatous Disease

Severe malignant osteopetrosis

- Was diagnosis confirmed by radiological evidence?

Yes

No

Other: Please list diagnosis:

#### HISTORY OF ANTIBIOTICS AND/OR ANTIFUNGAL MEDICATIONS TRIED AND FAILED

Medication Trial/ Previous Therapy	Date of Therapy		Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing
	Start Date	End Date			