

ACTIQ

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:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient Age:	Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed (# of units):
Diagnosis:	<input type="checkbox"/> Brand <input type="checkbox"/> Generic	Expected length of therapy:	
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did the member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY

Does patient have a breakthrough cancer pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does patient have acute or postoperative pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain :
Is patient on a long-acting opioid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list specific agents below

HISTORY OF FORMULARY MEDICATIONS USED TO TREAT THE ABOVE CONDITION

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