

# UPMC HEALTH PLAN

## Aldurazyme

### 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.*

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: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<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
Diagnosis:		Date of diagnosis:	

**Risk Factors/Medical History:**

Does member have a confirmed diagnosis of Mucopolysaccharidosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes: Please Choose disease form/severity	<input type="checkbox"/> Type I (Hurler and Hurler-Scheie forms) <input type="checkbox"/> Scheie form with moderate to severe symptoms

**History of medications previously tried and failed**

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

Please provide any additional information which should be considered in the space below:
