

# AMEVIVE

## 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: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Other (Please List):	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:		Member UPMC Health Plan ID Number:	Patient DOB:      Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty. Dispensed:
<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
Place of infusion? (Name and Location)	<input type="checkbox"/> Physician's Office:  <input type="checkbox"/> Hospital/Facility:	Will the drug be: (select one) <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	
Diagnosis:	Date of diagnosis:		

### Medical History

Psoriasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe AND % of BSA affected: <input type="checkbox"/> <10% <input type="checkbox"/> >10% AND duration of the disease: _____
Other? (Please List)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Does patient have Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient currently receiving methotrexate therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, start date:
Has patient received methotrexate for at least 3-6 months with an inadequate response?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, start date:      End date:
Has patient received a TNF blocking agent for at least 3-6 months with an inadequate response?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, start date:      End date:
Has patient experienced significant side effects/toxicity of methotrexate or a TNF blocking agent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please specify:
Does patient have contraindication to methotrexate or a TNF blocking agent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please specify:
Is patient using another TNF-blocking agent or other biologic agent in combination with drug requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please specify which medication and rationale for using combination therapy
Date of CD4 lymphocyte count:	Result of CD4 lymphocyte count:	

### History of formulary medications used to treat the above condition

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