UPMC HEALTH PLAN

ANCOBON

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 (8793) 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 DOB:**	**Patient Age:**
Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**
❑ **Brand**	❑ **Generic**		
❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	❑**Yes** ❑**No**
Diagnosis:		**Date of diagnosis:**	

Medical History

Please indicate the most appropriate diagnosis for the member:

- ☐ **Septicemia**
- ☐ **Endocarditis**
- ☐ **Urinary system infection**
- ☐ **Pulmonary infection**
- ☐ **Endophthalmitis**
- ☐ **Crytococcal infection**

Is the member receiving another antifungal in conjunction with Ancobon? ☐**Yes** ☐**No**

If Yes, please indicate medication name:____________________________

Please provide documentation of lab testing completed. Include results of CBC, electrolytes, BUN, and CHEM 7.