

UPMC HEALTH PLAN

BOTOX

Prior Authorization Form

IF THIS IS URGENT REQUEST, Please call the UPMC Health Plan Pharmacy Services,
Otherwise Please return the 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:	
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:
Diagnosis:		Date of diagnosis:	
<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
Is This Medication Being Used for a Work Related Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, List Date of Injury:			
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	
History of other Medications Used To Treat The Above Condition <i>(Specific clinical information is essential to determine whether this medication can be approved)</i>			
Medication Trial/ Previous Therapy	Date of Therapy Start Date End Date	Strength	Frequency
List Adverse Reactions/Side Effects/ Reason For Discontinuing			