

Cymbalta

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:	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:	

Medical History

Does patient have a psychiatric diagnosis? <input type="checkbox"/> Include previous therapies tried and failed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have Diabetic Neuropathy? <input type="checkbox"/> Include previous therapies tried and failed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have fibromyalgia? <input type="checkbox"/> Include copy of <u>chart documentation</u> showing the diagnosis of fibromyalgia with history of widespread pain involving the extremities for three months and localized area of tenderness. <input type="checkbox"/> Include copy of <u>chart documentation</u> showing previous therapies such as Gabapentin, Muscle Relaxants and Tricyclic Antidepressant tried and failed with dose, duration and rationale for failure <input type="checkbox"/> Include copy of <u>chart documentation</u> showing trial of exercise or physical therapy for fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list previous medication trials

Include drug name, strength, frequency, dates of therapy, and reason for discontinuing

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

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