

ARB Step

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

Risk Factors/Medical History:

Has the member previously tried and failed one of the following Ace Inhibitor for atleast 1 month?

<input type="checkbox"/> Accupril (Quinapril)	<input type="checkbox"/> Lotensin (Benazepril)	<input type="checkbox"/> Univasc (Moexipril)
<input type="checkbox"/> Altace (Ramipril)	<input type="checkbox"/> Mavik (Trandolapril)	<input type="checkbox"/> Vasotec (Enalapril)
<input type="checkbox"/> Aceon (Perindopril)	<input type="checkbox"/> Monopril (Fosinopril)	<input type="checkbox"/> Zestril (Lisinopril)
<input type="checkbox"/> Capoten (Captopril)	<input type="checkbox"/> Prinizil (Lisinopril)	

If Yes: Please list reason for discontinuation.

History of medications previously tried and failed

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

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