

EGRIFTA

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. 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	Dosage:	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	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing medication			
Diagnosis:		Date of Diagnosis:	

MEDICAL HISTORY

Please provide baseline waist circumference: _____			
Please provide baseline waist to hip ratio: _____			
Please provide baseline IGF-1 level: _____			
Please provide baseline fasting blood glucose: _____			
Does the member have lipodystrophy with excess abdominal fat?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have an underlying diagnosis of HIV?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member been on a stable antiretroviral regimen for at least 8 weeks?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member previously tried and failed physician-directed exercise and diet modifications?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member a woman and of childbearing potential?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, did the member have a baseline negative pregnancy test?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has chart documentation been provided showing specific examples of significant decreases in quality of life due to lipodystrophy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have a history of the following? (Select all that apply)			
<input type="checkbox"/> Head Irradiation	<input type="checkbox"/> Pituitary Tumor/Surgery	<input type="checkbox"/> Hypopituitarism	
<input type="checkbox"/> Hypophysectomy	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Not Applicable	

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Name	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:
