

UPMC HEALTH PLAN

ELIDEL / PROTOPIC 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

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 Age:	Patient DOB:	
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	If Protopic, Strength of ointment:	Frequency:	Qty Dispensed (tube size):	
Medical History				
Diagnosis:	Expected length of therapy:	Surface area to be treated:		
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing 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	
Does patient have a weakened or compromised immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain :		
Has patient tried a topical corticosteroid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list specific agents below		
History of formulary medications used to treat the above condition				
Medication Trial/ Previous Therapies	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing