LUPRON DEPOT, LUPRON DEPOT- PED, ELIGARD, VIADUR, ZOLADEX, TRELSTAR DEPOT, TRELSTAR LA

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:

Patient Name:	Member UPMC Health Plan ID Number:	Patient DOB:	Patient Age:

Drug Requested: ❑ Brand ❑ Generic	Strength:	Frequency:	Qty Dispensed:
❑ New Medication	❑ Ongoing Medication	If ongoing, provide date started:	
Diagnosis:		If medication is ongoing, Did member Show improvement while on therapy?	❑Yes ❑No

Place of infusion? (Name and Location)
❑ Physician's Office:
❑ Hospital/Facility:

Will the drug be: (select one)
❑ 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:_______________
❑ Billed by a pharmacy and delivered to the provider
❑ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY:

Brest Cancer?	❑ Yes ❑ No		
Prostate Cancer?	❑ Yes ❑ No		
Endometriosis?	❑ Yes ❑ No	If YES, what is the severity of the Endometriosis?	❑ Mild ❑ Moderate ❑ Severe
Has the member tried oral contraceptives?	❑ Yes ❑ No		
Has the diagnosis been confirmed by laparoscopy?	❑ Yes ❑ No	If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis.	
Uterine Leiomyomata or fibroids?	❑ Yes ❑ No		
Is the medication being used as a preoperativ adjuvant to surgery?	❑ Yes ❑ No	If no, please provide clinical rational for use.	
Dysfunctional Uterine Bleeding?	❑ Yes ❑ No		
Is the member undergoing endometrial ablation	❑ Yes ❑ No		
Central precocious puberty?	❑ Yes ❑ No	If YES, what age did the patient have an onset of secondary sexual characteristics?	

HISTORY OF PREVIOUS 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