

UPMC HEALTH PLAN

ERGOTAMINE

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:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand	<input type="checkbox"/> Generic		
<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
Diagnosis:		Date of diagnosis:	

Medical History

Does the member experience acute migraine attacks lasting over 48 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member experience frequent headache re-occurrence	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list previous medications failed and current prophylaxis therapies below:

History of other Medications Tried and Failed

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