UPMC HEALTH PLAN

EXUBERA

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:**	
Patient Name:	**Patient 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:**	**If medication is ongoing, Did member show improvement while on therapy?**	❑Yes ❑No
Diagnosis:		**Date of diagnosis:**	

Medical History

Is the member currently on subcutaneous insulin?	❑ Yes ❑ No	**If yes, please list type of insulin:** **If no, explain reason for failure or rationale why the member cannot take subcutaneous insulin:**
What is the member's baseline FEV_1?		
What is the member's carbon dioxide diffusing capacity (DL_{CO})?		
Does the member currently smoke or have a history of smoking within the last 6 months?	❑ Yes ❑ No	
Does the member have COPD, asthma, or an underlying chronic lung disease?	❑Yes ❑ No	
Is the member currently using broncodilators or other inhaled medications?	❑ Yes ❑ No	
If yes, Please list medications:		