

UPMC HEALTH PLAN

Fabrazyme

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: | Provider NPI #: |
| Patient Name: | Patient UPMC Health Plan ID Number: | Patient DOB: | Patient Age: |
| Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic | Strength: | 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 the member show improvement while on therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnosis: | | Date of diagnosis: | |

For Male Patients Complete the following:

| | |
|--|--|
| Does the member have a diagnosis of Fabry Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the diagnosis based on clinical symptoms or by Genetic Testing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For Female Patients Complete the following:

| | |
|---|--|
| Does the member have Presumed Symptoms of Fabry Disease based on family history and/or genetic testing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

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

Please provide any additional information which should be considered in the space below:

| |
|--|
| |
| |
| |

