UPMC HEALTH PLAN

FUZEON

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:**
Dosage:	**Frequency:**	**Qty to Dispensed**	
❑ **Brand**	❑ **Generic**		
❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member show improvement while on therapy?**	❑**Yes** ❑**No**

MEDICAL HISTORY

Does the patient have HIV / AIDS and has failed numerous other treatments?	❑ **Yes** ❑ **No**	**If yes, please provide other therapies tried below.**
Other diagnosis if not HIV / AIDS		

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