

# UPMC HEALTH PLAN

## Intelence and Selzentry 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.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b>	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	<b>If ongoing, provide date started:</b>	<b>If medication is ongoing, Did member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	

**Medical History**

*For Selzentry requests only*

Has member had a diagnostic tropism test?       Yes       No

Is CCR-5 tropic HIV-1 virus present?       Yes       No

**Please complete for all requests**

**Please list previous medication trials. Include drug name, strength, frequency, dates of therapy, and reason for discontinuation.**

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing