

# UPMC HEALTH PLAN

## INVEGA

### 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.*

<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"/> Brand <input type="checkbox"/> Generic			
<input type="checkbox"/> New 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"/> Ongoing medication			<input type="checkbox"/> No
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	

### Medical History

Please indicate below atypical anti-psychotics previously tried:

History of Formulary Medications Used to treat the above condition  
(Specific Clinical Information is Essential to Determine Whether this Medication can be Approved)

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