

# UPMC HEALTH PLAN

## Kuvan

### 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>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>	<b>Patient weight:</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**

What is the member's serum phenylalanine level? \_\_\_\_\_

Date of test: \_\_\_\_\_