

UPMC HEALTH PLAN

LIALDA

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:	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 <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

Medical History

Has the member previously tried and failed any of the following medications?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Please indicate drug:				
<input type="checkbox"/> Balsalazide (Colazal)		<input type="checkbox"/> Asacol		
<input type="checkbox"/> Apriso		<input type="checkbox"/> Asacol HD		
Please indicate reason(s) for discontinuation:				

History of previous medications used to treat the above condition

Medication Name	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

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