

UPMC HEALTH PLAN

Lysteda

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 <i>Incomplete responses may delay this request.</i>			
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:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			
<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 the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Risk Factors/Medical History:			
Has the member tried and failed combined hormonal contraceptives?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please list contraceptives below:
Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation
Has the member tried and failed NSAIDs?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please list NSAIDs below:
Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation
Does the member have a history of Active Thromboembolic Disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a risk of Thrombosis or Thromboembolism?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have hypersensitivity to tranexamic acid?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Lysteda be used in combination with a hormonal contraceptive?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list below.
Medication Name	Strength/Frequency	Dates of Therapy	
Please list below any other previous therapies tried:			
Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation
Please include the following chart documentation:			
Documentation of clinical work-up to rule out other possible pathology		<input type="checkbox"/> Included	<input type="checkbox"/> Not Available
Documentation showing clinical rationale for the diagnosis		<input type="checkbox"/> Included	<input type="checkbox"/> Not Available
Documentation showing exclusion of other possible pathology		<input type="checkbox"/> Included	<input type="checkbox"/> Not Available
Please provide any additional information which should be considered in the space below:			