

UPMC HEALTH PLAN

MYOZYME

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. 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:
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	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?		<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing Medication				<input type="checkbox"/> No
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one)		
Please provide hospital/facility name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____		
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider		
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient		
Clinical History				
Does the member have a diagnosis of Pompe Disease?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please specify:				
Please provide any additional information which should be considered in the space below:				