

# UPMC HEALTH PLAN

## OFORTA

### 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.** *Incomplete responses may delay this request.*

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient Age:	Patient DOB:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Expected length of therapy:
<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
Place of administration? <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility	Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide 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		
Please provide facility/provider name and address:			
Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status. <input type="checkbox"/> Chart documentation enclosed <input type="checkbox"/> Chart documentation not available			
Please indicate the diagnosis and answer the corresponding questions:			
<input type="checkbox"/> B-cell Chronic Lymphocytic Leukemia (CLL)	Is Oforta being used as monotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member tried and failed at least one standard alkylating-agent containing regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete below:		
<b>Medication Name</b>	<b>Strength/Frequency</b>	<b>Dates of Therapy</b>	<b>Reason for Discontinuation</b>
<input type="checkbox"/> Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. <input type="checkbox"/> Clinical literature/studies enclosed <input type="checkbox"/> Clinical literature/studies not available		
Is Oforta being used in combination with any other therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below.			
<b>Medication Name</b>	<b>Strength/Frequency</b>	<b>Dates of Therapy</b>	<b>Reason for Discontinuation</b>
Please list below any other previous therapies tried:			
<b>Medication Name</b>	<b>Strength/Frequency</b>	<b>Dates of Therapy</b>	<b>Reason for Discontinuation</b>
Please provide any additional information which should be considered in the space below:			