

UPMC HEALTH PLAN

ORFADIN

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
Please indicate place of administration / infusion?	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility	Please indicate how medication will be billed:	
Please provide facility/provider name and address:		<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 indicate the diagnosis and answer the corresponding questions:			
<input type="checkbox"/> Hereditary Tyrosinemia type 1 (HT-1)	Is Orfadin being used as an adjunct to dietary restriction of tyrosine and phenylalanine?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Did the member have a laboratory test of baseline SA level?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Please provide baseline SA level: _____		
	Date of test _____		
	Did the member undergo baseline liver evaluation and ophthalmologic testing?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is documentation available of progressive SA suppression through laboratory test?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, date of test: _____			
<input type="checkbox"/> Other Diagnosis, please list:			
Please list below any other previous therapies tried:			
Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation
Please provide any additional information which should be considered in the space below:			