

UPMC HEALTH PLAN

PREVACID NAPRAPAC

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:	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 member Show improvement while on therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing medication					
Diagnosis:			Date of diagnosis:		

MEDICAL HISTORY

Does the member have a gastric ulcer or is a high risk for a gastric ulcer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member currently taking an NSAID (ex. Naproxen, Ibuprofen)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member tried and failed Prilosec OTC for at least 2 weeks?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member currently taking Celebrex?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

History of Previous H2 blocker or PPI Therapy Medications

Previous H2 blocker or PPI Therapy	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:
