

UPMC HEALTH PLAN

Samsca

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: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Expected length of therapy:
---	------------------	-------------------	------------------------------------

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<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:	<input type="checkbox"/> Hypervolemic Hyponatremia	Date of diagnosis:
	<input type="checkbox"/> Euvolemic Hyponatremia	
	<input type="checkbox"/> Other (please specify)	

Medical History

Please indicate Serum Sodium level prior to beginning Samsca? _____

Does the member have symptomatic hyponatremia with failure to fluid restriction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Samsca initiated and titrated in a hospital setting with close serum monitoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member Anuric?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member able to sense and respond appropriately to thirst?	<input type="checkbox"/> Yes <input type="checkbox"/> No

History of Other Medications Tried and Failed

Medication Trail/ Previous Therapy	Date of Therapy		Strength	Frequency	List adverse reactions/Side Effects/Reason for discontinuing
	Start Date	End Date			

Please provide any additional information which should be considered in the space below:
