

UPMC HEALTH PLAN

Serostim

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 800-396-4139

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:
<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"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:			

MEDICAL HISTORY

Does the member have clear documentation of HIV infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient compliant with Antiretroviral medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member tried and failed Marinol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the member tried and failed Megace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have a documented involuntary weight loss of at least 10% from baseline premorbid weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have any type of active malignancy other than Kaposi's Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Please specify the type of active malignancy:		

Please list all other medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

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