

## Somatuline Depot 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. 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:			
<b>Please indicate the diagnosis and answer the corresponding questions:</b>			
<input type="checkbox"/> Acromegaly	Is the medication being prescribed by or in consultation with an endocrinologist?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please provide the member's IGF-1 level: _____		
	Laboratory reference range: _____		
	Date of test _____		
	Please provide the member's Growth Hormone (GH) level during oral glucose tolerance test _____		
Date of Test: _____			
Did the member have an inadequate response to surgery or radiation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If no, Please provide documentation that these therapies are not appropriate.</b>			
<input type="checkbox"/> Chart documentation enclosed		<input type="checkbox"/> Chart documentation not available	
<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
<b>Please provide any additional information which should be considered in the space below:</b>			