

# SYMBYAX

## 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:
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Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			

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			

Please indicate the diagnosis and answer the corresponding questions on the left:

<input type="checkbox"/> Bipolar Depression	Has the member tried Zyprexa in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Major Depressive Disorder	Please list below Antidepressants the member has previously tried. MUST include dates of therapy and reason for discontinuation
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Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

<input type="checkbox"/> Major Depressive Disorder (cont)	Please List any other medications the member has used in conjunction with the Antidepressants or for Depression. MUST include dates of therapy and reason for discontinuation
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Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

<input type="checkbox"/> Other	Please specify:
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Please provide any additional information which should be considered in the space below:
