

TEMODAR

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. 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:
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Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Expected length of therapy:
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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
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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
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Please provide facility/provider name and address:

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.
 Chart documentation enclosed Chart documentation not available

Please indicate the diagnosis and answer the corresponding questions:

<input type="checkbox"/> Glioblastoma Multiforme (GBM)	Is Temodar being used concomitantly with radiotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is Temodar being used as maintenance treatment for this member?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Refractory Anaplastic Astrocytoma	Was member previously on a drug regimen containing nitrosourea and procarbazine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list below:	

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

<input type="checkbox"/> Relapsed, Refractory, or Progressive Malignant Glioma	Is Temodar being used as monotherapy for this member? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Melanoma	Please indicate disease status: <input type="checkbox"/> Metastatic	Is Temodar being used as monotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<input type="checkbox"/> Adult Acute Leukemia (Please indicate type)	<input type="checkbox"/> Acute lymphoblastic leukemia (ALL)	<input type="checkbox"/> Acute Myeloid Leukemia (AML)
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<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
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Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.

Is Temodar being used in combination with any other therapies? Yes No If yes, please complete below:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

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