

UPMC HEALTH PLAN

ARB Step

Avapro, Avalide and Benicar/Benicar HCT, Tribenzor (UPMC for Life Medicare)
 Atacand/Atacand HCT, Avapro, Avalide, Azor, Benicar/Benicar HCT, Teveten/Teveten HCT, Tribenzor (UPMC Health Plan Commercial)

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

For all requests, please complete the following.

Diagnosis:

Please indicate if the member has previously tried and failed any of the following Angiotensin II receptor blockers (ARB's):

<input type="checkbox"/> Losartan (Cozaar)	<input type="checkbox"/> Diovan,	<input type="checkbox"/> Micardis
<input type="checkbox"/> Losartan/hydrochlorothiazide (Hyzaar)	<input type="checkbox"/> Diovan HCT	<input type="checkbox"/> Micardis HCT
<input type="checkbox"/> Exforge	<input type="checkbox"/> Exforge HCT	<input type="checkbox"/> Twynsta

If yes, please indicate reason for discontinuation:

Please list Below any other medication previously tried to treat the member's condition:

Medication Name	Strength	Frequency	Dates of Therapy	Reason for Discontinuation

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