

# UPMC HEALTH PLAN

## ULORIC

### 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.*

|  |  |  |   |
|--|--|--|---|
| <b>Office Contact:</b>   |  | <b>Provider Specialty:</b>   |   |
| <b>Provider First Name:</b>  |  | <b>Provider Last Name:</b>   |   |
| <b>Provider Phone:</b>   |  | <b>Provider Fax:</b>   | <b>Provider NPI #:</b>                                      |
| <b>Patient Name:</b>   |  | <b>Patient DOB:</b>  | <b>Patient Age:</b>   |
| <b>Patient UPMC Health Plan ID Number:</b>   |  |  |   |
| <b>Drug Requested:</b><br><input type="checkbox"/> Brand <input type="checkbox"/> Generic                            | <b>Strength:</b>                         | <b>Frequency:</b>  | <b>Qty Dispensed:</b>                                       |
| <i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i> |  |  |   |
| <input type="checkbox"/> New medication<br><input type="checkbox"/> Ongoing medication                               | <b>If ongoing, provide date started:</b> | <b>If medication is ongoing, Did member Show improvement while on therapy?</b> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| <b>Diagnosis:</b>  |  | <b>Date of diagnosis:</b>  |   |

### Medical History

|  |                              |                             |
|--|------------------------------|-----------------------------|
| <b>Has the member failed or experienced intolerance to Allopurinol?</b>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Does the member have renal insufficiency or chronic kidney disease?</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

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