

**LUPRON DEPOT, LUPRON DEPOT- PED, ELIGARD, FIRMAGON, ZOLADEX,  
VANTAS, SUPPRELIN LA, TRELSTAR DEPOT, TRELSTAR LA, SYNAREL**

**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:	Member 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 the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing Medication			

Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	<b>Will the drug be: (select one)</b> <input type="checkbox"/> Billed directly by the provider via JCODE 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 hospital/facility name and address:		

**Please indicate the diagnosis on the left and complete the corresponding questions.**

<input type="checkbox"/> Prostate Cancer	
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Endometriosis	What is the severity of the Endometriosis? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	Has the diagnosis been confirmed by laparoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis.
	Has the member tried oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Central precocious puberty	What age did the patient have an onset of secondary sexual characteristics? _____
<input type="checkbox"/> Dysfunctional Uterine Bleeding	Is the member undergoing endometrial ablation <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Uterine Leiomyomata or fibroids	Does the member have anemia (Hemoglobin less than 11). <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the medication being used as a preoperative adjuvant to surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide clinical rationale for use.

**HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION**

Medication Trial/ Previous Therapies	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

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