

XOLAIR

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: _____

Drug Requested: _____ Strength: _____ Frequency: _____ Qty Dispensed: _____
 Brand Generic

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication Ongoing medication If ongoing, provide date started: _____ If medication is ongoing, Did the member show improvement while on therapy? Yes No

Diagnosis: _____ Date of diagnosis: _____

Please indicate place of administration? Physician's Office Hospital/Facility

Please provide facility/provider name and address: _____ Please indicate how medication will be billed:
 Billed directly by the provider via JCODE Provide JCODE: _____
 Billed by a pharmacy and delivered to the provider
 Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Patient Height: _____ Patient Weight: _____ Pretreatment Serum IgE Level? Yes No

If YES, IgE Level _____ IU/ml Test Date: _____

History of positive skin or RAST Test to a perennial allergen AND/OR for seasonal aeroallergens? Yes No

Is patient currently taking any of the following medications (check all that apply and indicate length of therapy on each):

Short Acting Beta Agonists _____ Inhaled Corticosteroids _____
 Long Acting Beta Agonists _____ Immunotherapy _____
 Oral Steroids _____ Leukotriene Modifiers _____

Other Medications(Please Specify): _____

Has patient been hospitalized due to asthma? Yes No

Has patient had an increased need for short-acting inhaled beta2 agonists? Yes No

HISTORY OF FORMULARY MEDICATIONS USED TO TREAT THE ABOVE CONDITION

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

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