Rapamune, Zortress

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 800-396-4139 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:**	**Provider NPI #:**	
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**

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 member Show improvement while on therapy?	❑Yes ❑No

Diagnosis:

Please indicate place of administration? ❑Physician 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

Did the member undergo a solid organ transplant?	❑ Yes ❑ No
If Yes, Please indicate which organ_________________	
Does the member have renal dysfunction?	❑ Yes ❑ No
If the member had a heart transplant do they have coronary allograft vasculpathy?	❑ Yes ❑ No
Is the member seronegative for cytomegalovirus (CMV)?	❑ Yes ❑ No
Is the donor organ seropostive for CMV?	❑ Yes ❑ No
Does the member have sympotomatic CMV disease?	❑ Yes ❑ No

Please indicate if the member has tried any of the following drugs:

❑ Immuran (azathioprine ❑ Prograff (tacrolimas)

❑ Myfortic (mycophenolate) ❑ Cellcept (mycophenolate ❑ Sandiminne/Noral/Gengraf (Cyclosporine)

Please indicate below reason for discontinuation:

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please list all medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

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