Arcalyst PA 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)

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: 

Please type or print neatly

Specific alternate medications 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:

Medical History
Is the member using another TNF-blocking agent or biologic agent (such as Kineret) in combination with the requested medication?  
Yes  
No

Date of PPD (Tuberculosis Test):  ___________________
Result of PPD test:____________________________

History of medications previously tried and failed

<table>
<thead>
<tr>
<th>Medication Trial/Previous Therapy</th>
<th>Date of Therapy Start Date</th>
<th>Date of Therapy End Date</th>
<th>Strength</th>
<th>Frequency</th>
<th>List adverse reactions/side effects/ reason for discontinuing</th>
</tr>
</thead>
</table>

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


Arcalyst PA form  All PA forms available at www.upmchealthplan.com/providers/pa_forms.html  February 2011