UPMC Health Plan

CAPRELSA & COMETRIQ

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 that substantiates the need for an exception to using formulary alternatives (e.g., 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: ☐ **Brand** ☐ **Generic**	**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 the member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:

Please indicate place of administration:	☐ **Physician Office** ☐ **Hospital/facility** ☐ **Patient Home**	**Please indicate how medication will be billed:** ☐ **Billed directly by the provider via JCODE** **JCODE:_____** ☐ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

MEDICAL HISTORY

Does the member have medullary thyroid cancer? **If yes, please indicate if disease is any of the following:** ☐ Unresectable ☐ Progressive ☐ Locally-advanced ☐ Metastatic	☐ **Yes** ☐ **No**
If no, please provide clinical literature/studies to support the request for off-label use.	☐ **Documentation enclosed** ☐ **Documentation not available**

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

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

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