UPMC HEALTH PLAN

Cerezyme, Elelyso, & VPRIV
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

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:**

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**

Please indicate place of administration/ infusion: ☐ Physician's Office ☐ Hospital/Facility	**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
Please provide facility/provider name and address:	

MEDICAL HISTORY

Does the member have a diagnosis of Gaucher Disease? ☐ **Yes** ☐ **No**

If No, Please provide the diagnosis:

Does the member have any of the following conditions:

- ☐ **Thrombocytopenia**
- ☐ **Anemia**
- ☐ **Hepatomegaly**
- ☐ **Splenomegaly**
- ☐ **Bone Disease**
- ☐ **Other, Please specify:**

Please list all other 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: