COMPOUNDED MEDICATIONS

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:**

Name of Compound: **❑ 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 member show improvement while on therapy?**	**❑Yes** **❑No**

Diagnosis:	**Date of Diagnosis:**

Is This Medication Being Used for a Work Related Injury? **❑ Yes ❑ No** **If Yes, List Date of Injury:_____**

Dosage form requested:
❑ Capsule ❑ Liquid ❑ Topical Cream ❑ Suppository ❑ Other- please specify_____

Name of each ingredient *(Include all drugs and fillers)*	**Total amount** of each ingredient in the compound *(ie grams, ounces)*	**Number of Capsules or volume of liquid being dispensed**

History of medications previously tried and failed

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

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