Demser and Dibezyline

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: ☐**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:

MEDICAL HISTORY

Does the member have a diagnosis of pheochromocytoma?	☐**Yes** ☐**No**
Does the member have malignant pheochromocytoma?	☐**Yes** ☐**No**
Does the member have surgical resection planned?	☐**Yes** ☐**No**
If no, does the member have a contraindication to surgery?	☐**Yes** ☐**No**
Is the member currently taking an alpha-adrenergic agonist or calcium channel blocker?	☐**Yes** ☐**No**

Please list all medications the member has previously tried and failed 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: