UPMC Health Plan

Dificid
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:**
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:

MEDICAL HISTORY

Please indicate if the member previously tried the following: ❑ Vancomycin ❑ Metronidazole

If Yes, Please indicate reason for discontinuation:

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 which should be considered in the space below: