UPMC HEALTH PLAN

ELIDEL / PROTOPIC
PRIOR AUTHORIZATION FORM

IF THIS IS URGENT REQUEST, PLEASE CALL THE UPMC HEALTH PLAN PHARMACY SERVICES, OTHERWISE PLEASE RETURN THE 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 Age:**	**Patient DOB:**
Drug Requested: ❑ Brand ❑ Generic	**If Protopic, Strength of ointment:**	**Frequency:**	**Qty Dispensed (tube size):**

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

Medical History

Diagnosis:	**Expected length of therapy:**	**Surface area to be treated:**

Does patient have a weakened or compromised immune system?	❑ Yes ❑ No	**If yes, please explain :**
Has patient tried a topical corticosteroid?	❑ Yes ❑ No	**If yes, please list specific agents below**

History of formulary medications used to treat the above condition

Medication Trial/ Previous Therapies	Date of Therapy Start Date	Date of Therapy 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: