HORIZANT

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. 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:**

Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**	**Patient Age:**

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**

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ Restless Leg Syndrome	Has the member tried pramipexole at a dose of at least 0.5mg per day?	☐ Yes ☐ No
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried ropinorole at a dose of at least 4mg per day?	☐ Yes ☐ No
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried gabapentin at a dose of at least 1800mg per day?	☐ Yes ☐ No
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
☐ Postherpetic Neuralgia	Has the member tried gabapentin at a dose of at least 1800mg per day?	☐ Yes ☐ No
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
	Has the member tried a tricyclic antidepressant?	☐ Yes ☐ No
	If yes, please provide dates of therapy:	
	Reason for discontinuation:	
☐ Other	Please provide the member's diagnosis:	
	Date of diagnosis?	

History of medications previously tried and failed

Medication Trial/ Previous Therapy	Dates 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: