HORIZANT
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
PHONE 800-979-UPMC (8762)
FAX 412-454-7722

UPMC HEALTH PLAN PHARMACY SERVICES

PLEASE TYPE OR PRINT NEATLY
Please complete all sections of this form. Incomplete responses may delay this request.

<table>
<thead>
<tr>
<th>Office Contact:</th>
<th>Provider Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider First Name:</td>
<td>Provider Last Name:</td>
</tr>
<tr>
<td>Provider Phone:</td>
<td>Provider Fax:</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>Patient UPMC Health Plan ID Number:</td>
</tr>
<tr>
<td>Drug Requested:</td>
<td>Strength:</td>
</tr>
</tbody>
</table>

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 ropinirole 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

<table>
<thead>
<tr>
<th>Medication Trial/ Previous Therapy</th>
<th>Dates of Therapy</th>
<th>Strength</th>
<th>Frequency</th>
<th>List Adverse Reactions/ Side Effects/ Reason For Discontinuing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Start Date</td>
<td>End Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Horizant PA form

All PA forms available at www.upmchealthplan.com/providers/pa_forms.html

July 2012