UPMC HEALTH PLAN

INVEGA SUSTENNA, RISPERDAL CONSTA, AND ZYPREXA RELPREVV
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 place of administration / infusion?	☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home
Please provide facility/provider name and address:	**Please indicate how medication will be billed:** ☐ Billed directly by the provider via JCODE Provide JCODE:_____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient

Medical History

Please indicate diagnosis:

☐ Schizophrenia
☐ Bipolar Disorder
☐ Other, Please specify:

Has the member tolerated a previous trial of oral risperidone (Risperdal)? ☐ Yes ☐ No

If no, please describe:_____

Please list any oral antipsychotics the member has previously tried or is currently using

Medication Trial/Previous Therapy	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: