UPMC HEALTH PLAN

MYOZYME and LUMIZYME

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: ❑ **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**

Please indicate place of administration:	❑ Physician's Office ❑ Hospital/Clinic	**Will the drug be: (select one)** ❑ Billed directly by the provider via JCODE JCODE: _____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient
Please provide hospital/facility name and address:		

Clinical History

Does the member have a diagnosis of Pompe Disease? **If no, please specify:**	❑**Yes** ❑**No**

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