UPMC HEALTH PLAN

# Lysteda

## 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**
***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:** | **Patient Age:** |

| | | | |
|---|---|---|---|
| **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 |

| | |
|---|---|
| **Diagnosis:** | **Date of diagnosis:** |

## Risk Factors/Medical History:

| | | | |
|---|---|---|---|
| **Has the member tried and failed combined hormonal contraceptives?** | ❑ Yes ❑ No | **If Yes, Please list contraceptives below:** | |
| **Medication Name** | **Strength/Frequency** | **Dates of Therapy** | **Reason for Discontinuation** |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| **Has the member tried and failed NSAIDs?** | ❑ Yes ❑ No | **If Yes, Please list NSAIDs below:** | |
| **Medication Name** | **Strength/Frequency** | **Dates of Therapy** | **Reason for Discontinuation** |
| | | | |
| | | | |

| | |
|---|---|
| **Does the member have a history of Active Thromboembolic Disease?** | ❑ Yes ❑ No |
| **Does the member have a risk of Thrombosis or Thromboembolism?** | ❑ Yes ❑ No |
| **Does the member have hypersensitivity to tranexamic acid?** | ❑ Yes ❑ No |

**Will Lysteda be used in combination with a hormonal contraceptive? ❑Yes ❑No If yes, please list below.**

| **Medication Name** | **Strength/Frequency** | **Dates of Therapy** |
|---|---|---|
| | | |
| | | |

**Please list below any other previous therapies tried:**

| **Medication Name** | **Strength/Frequency** | **Dates of Therapy** | **Reason for Discontinuation** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please include the following chart documentation:**

| | | |
|---|---|---|
| **Documentation of clinical work-up to rule out other possible pathology** | ❑ Included | ❑ Not Available |
| **Documentation showing clinical rationale for the diagnosis** | ❑ Included | ❑ Not Available |
| **Documentation showing exclusion of other possible pathology** | ❑ Included | ❑ Not Available |

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