UPMC Health Plan

MYOZYME

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: