UPMC HEALTH PLAN

NPLATE

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 AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. 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 (# of units):**

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 member Show improvement while on therapy?**	❑**Yes** ❑**No**
Diagnosis:		**Date of diagnosis:**	

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:		

Will Nplate be administered by the prescriber or other healthcare provider? ❑**Yes** ❑**No**

MEDICAL HISTORY

For Initial Authorization requests please complete the following:

Baseline Platelet Count :_____ **Date of test:**_____

Has the member previously had an adequate response or intolerance to corticosteroids? ❑**Yes** ❑**No**

For Continuation Authorization requests please complete the following:

Platelet Count while on Nplate:_____ **Date of test:**_____

Does the member have disease improvement? ❑**Yes** ❑**No**

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