UPMC HEALTH PLAN

NULOJIX
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

THIS SECTION FOR PROVIDER USE ONLY—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:**	**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:**	

Please indicate place of administration/ infusion: ☐Physician's Office ☐Hospital/Facility	**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
Please provide facility/provider name and address:	

Risk Factors/Medical History:

Will the member be undergoing or has the member undergone a renal transplant?	☐**Yes** ☐**No**
Has the member previously tried cyclosporine or tacrolimus?	☐**Yes** ☐**No**
If yes, please list reason for discontinuation:	
Is the member at risk of renal failure before transplant?	☐**Yes** ☐**No**
Will Nulojix be used with basiliximab induction at time of transplant?	☐**Yes** ☐**No**
Will Nulojix be used in conjunction with mycophenolate and corticosteroids?	☐**Yes** ☐**No**
Has the member demonstrated immunity to Epstein Barr Virus (EBV) as demonstrated by EBV serology?	☐ Yes ☐No
Does the member have a recent negative tuberculin PPD test? **Date of the test:** _____	☐**Yes** ☐**No**
Does the member have evidence of infection including but not limited to: progressive multifocal leukoencephalopathy (PML), Cytomegalovirus (CMV), and Polyoma virus-associated nephropathy (PVAN)?	☐**Yes** ☐**No**
Does the member have a history of or currently have active malignancy?	☐**Yes** ☐**No**

History of medications previously tried and failed

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: