UPMC HEALTH PLAN

OFORTA

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:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**
Drug Requested: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Expected length of therapy:**

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

Place of administration? ❑Physician Office ❑Hospital/Facility

Please provide facility/provider name and address:

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 pertinent progress notes and lab/radiology reports that describe the member's current disease status.

☐ **Chart documentation enclosed** ☐ **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

❑ B-cell Chronic Lymphocytic Leukemia (CLL)

Is Oforta being used as monotherapy? ❑Yes ❑No

Has the member tried and failed at least one standard alkylating-agent containing regimen? ❑Yes ❑No If yes, please complete below:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

❑ Other Diagnosis, please list:

Please provide clinical literature/studies to support request for off-label use.

☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

Is Oforta being used in combination with any other therapies? ❑Yes ❑No If yes, please list below.

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

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