UPMC Health Plan

NESINA, KAZANO, OSENI, ONGLYZA, & KOMBIGLYZE XR

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**

Diagnosis:

Medical History

Has the member previously failed or had intolerance to Januvia, Janumet, Janumet XR, Jentadueto, Juvisync, or Tradjenta? ☐ Yes ☐ No

If yes, please complete below:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please list all diabetic medications the member has previously tried or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

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