UPMC HEALTH PLAN

PROTON PUMP INHIBITOR (ALL PRODUCTS)
STEP-UP THERAPY REQUEST FORM

PLEASE PRINT AND RETURN 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 Name:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**	**Anticipated Duration of Use:**

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:

OTHER CONSIDERATION

❑ **Unable to swallow tablets due to:** ❑Age ❑Medical Condition

Please describe:

History of Previous H2 blocker or PPI Therapy Medications

Previous H2 blocker or PPI Therapy	Date of Therapy		Strength	Frequency	List Adverse Reactions/side Effects/ Reason for Discontinuing
	Start Date	End Date			

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