UPMC HEALTH PLAN

PROLIA

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 DOB:**	**Patient Age:**

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 the member show improvement while on therapy?**	**❑ Yes** **❑ No**

Diagnosis:

Please indicate place of administration:	❑ Physician's Office ❑ Hospital/Clinic
Please provide hospital/facility name and address:	

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

MEDICAL HISTORY

Please provide baseline bone mineral density (BMD) T score: _____ Date of test:_____

Please provide current bone mineral density (BMD) T score: _____ Date of test:_____

Please provide BMD skeletal site measured: _____

Does the member have a history of fracture? ❑Yes ❑No

If yes, please indicate fracture site: _____

Please include fracture date: _____

HISTORY OF MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	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: