UPMC HEALTH PLAN

Provenge
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 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Please complete all sections of this form AND include details of past relevant medical treatment. 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:	**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:**
Diagnosis:	

MEDICAL HISTORY

Please provide a copy of progress notes and lab/radiology reports that document the following:
☐ Chart documentation enclosed ☐ Chart documentation not available

☐	**Diagnosis of castrate resistant (hormone refractory) prostate cancer**
☐	**Serum testosterone level**
☐	**Radiological evidence of metastatic disease to soft tissue and/or bone**
☐	**Documentation confirming the member has no evidence of any visceral metastases (e.g. lung, liver, brain)**
☐	**Documentation confirming disease progression at metastatic sites or by serial prostate specific antigen measurements following treatment with androgen deprivation therapy or orchiectomy**
☐	**Documentation confirming the member is asymptomatic or minimally symptomatic as evidenced by not having cancer-related pain**

Please complete the following questions

Did the member have a bilateral orchiectomy?	**☐Yes ☐No**
Please provide the member's ECOG performance status:_____	
Will the member be using chemotherapy or immunosuppressants concurrently with Provenge?	**☐Yes ☐No**
If yes, please indicate drug name:_____	
Please provide date for planned or anticipated plasmapheresis:_____	

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