Rapamune, Zortress

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
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:**	**If medication is ongoing, Did member Show improvement while on therapy?**	☐**Yes** ☐**No**

Diagnosis:

Please indicate 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**

MEDICAL HISTORY

Did the member undergo a solid organ transplant?	☐**Yes** ☐**No**
If Yes, Please indicate which organ:	
Does the member have renal dysfunction?	☐**Yes** ☐**No**
If the member had a heart transplant does he/she have coronary allograft vasculopathy?	☐**Yes** ☐**No**
Is the member seronegative for cytomegalovirus (CMV)?	☐**Yes** ☐**No**
Is the donor organ seropositive for CMV?	☐**Yes** ☐**No**
Does the member have symptomatic CMV disease?	☐**Yes** ☐**No**

Please indicate if the member has tried any of the following drugs:

☐**Imuran (azathioprine)** ☐**Prograf (tacrolimus)**
☐**Myfortic (mycophenolate)** ☐**Cellcept (mycophenolate)** ☐**Sandimmune/Neoral/Gengraf (Cyclosporine)**

Please indicate below reason for discontinuation:

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

Please list all 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: