UPMC Health Plan

Rescula, Travoprost (Travatan), Travatan Z, Zioptan

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 Member ID #:**	**Patient DOB:**	**Patient age:**

Drug requested: **□ Brand □ Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

□ New medication **□ Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	**□ Yes** **□ No**

Diagnosis:

Please indicate place of administration	□ Physician office □ Hospital/Clinic □ Patient home	**Will the medication 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
Please provide hospital/facility name and address:		

Medical History

Has the member previously tried and latanoprost (Xalatan)?	**□ Yes □ No**

If yes, please provide reason for discontinuation:

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

Medication Name	Strength	Frequency	Start date	End date	Reason for failure or discontinuation

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