ELIGARD, FIRMAGON, LEUPROLIDE, LUPRON DEPOT, LUPRON DEPOT- PED, SUPPRELIN LA, SYNAREL, TRELSTAR DEPOT, TRELSTAR LA, VANTAS, ZOLADEX

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

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:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Member UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐**Brand** ☐**Generic**	**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 the member show improvement while on therapy?**	☐**Yes** ☐**No**
Please indicate place of administration: ☐ Physician's Office ☐ Hospital/Clinic ☐ Patient Home		**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	
Please provide hospital/facility name and address:			

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ **Prostate Cancer**	
☐ **Breast Cancer**	
☐ **Endometriosis**	What is the severity of the Endometriosis? ☐Mild ☐Moderate ☐Severe Has the diagnosis been confirmed by laparoscopy? ☐Yes ☐No If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis. Has the member tried oral contraceptives? ☐Yes ☐No
☐ **Central precocious puberty**	What age did the patient have an onset of secondary sexual characteristics? _____
☐ **Dysfunctional Uterine Bleeding**	Is the member undergoing endometrial ablation ☐Yes ☐No
☐ **Uterine Leiomyomata or fibroids**	Does the member have anemia (Hemoglobin less than 11). ☐Yes ☐No Is the medication being used as a preoperative adjuvant to surgery? ☐Yes ☐No If no, please provide clinical rationale for use.

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/

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