UPMC HEALTH PLAN

ZORBTIVE

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:	**Patient 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**

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration?	❑Physician's Office ❑Hospital/Facility	**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
Please provide facility/provider name and address:		

Medical History

Please submit chart documentation in support of a diagnosis of short bowel syndrome:

- ❑ **Member has malabsorption from the small intestine that is marked by diarrhea, malnutrition,**
- ❑ **and steatorrhea**
- ❑ **Resection of the small intestine**
- ❑ **Length of small intestine and jejunum and/or ileum**

Is the member receiving adequate nutritional support as determined?	❑ **Yes** ❑ **No**
Does the member have an active malignancy?	❑ **Yes** ❑ **No**

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