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 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

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: