UPMC HEALTH PLAN

Actonel, Actonel with Calcium, Boniva and Atelvia Step Therapy
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

THIS SECTION FOR PROVIDER USE ONLY—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:**

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:**

Diagnosis:	**Date of diagnosis:**

Medical History

Has the member previously tried alendronate (Fosamax)? **If yes, please list dates of therapy and reason for discontinuation:**	❑ Yes ❑ No
Does the member have Paget's Disease?	❑ Yes ❑ No
Does the member have an abnormality of the esophagus that delays esophageal emptying (stricture or achalasia)? **If yes, please indicate type of abnormality:**	❑ Yes ❑ No

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