UPMC HEALTH PLAN

AUBAGIO

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

Please complete all sections of this form AND include details of past relevant medical treatment.
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:

MEDICAL HISTORY

Does the member have relapsing form of Multiple Sclerosis?	☐ Yes ☐ No
Has the member previously tried an interferon product (such as Avonex, Betaseron, Extavia, or Rebif)?	☐ Yes ☐ No
If yes, please indicate name of product and dates of trial:	
Please indicate reason(s) for failure:	
Has the member previously tried glatiramer (Copaxone)?	☐ Yes ☐ No
If yes, please indicate dates of trial:	
Please indicate reason(s) for failure:	
Did the member have a recent (within the past 6 months) complete blood count (CBC)?	☐ Yes ☐ No
If yes, please indicate date:	
Did the member have a recent (with in the past 6 months) transaminase and bilirubin level?	☐ Yes ☐ No
If yes, please indicate date:	
Does the member have severe hepatic impairment?	☐ Yes ☐ No
Does the member have evidence of active infection?	☐ Yes ☐ No
Female members: If the member is of childbearing potential, has she had a baseline (within 1 month) negative pregnancy test prior to initiation of therapy? If yes, please indicate date of test: ____________________	☐ Yes ☐ No
Female members: If the member is of childbearing potential, is she currently using reliable contraception during treatment?	☐ Yes ☐ No
Please provide date of PPD (tuberculin) test: ____________________ Results: ☐ Positive ☐ Negative	
Is the member on concomitant therapy with antineoplastic, immunosuppressive therapy, or immune modulating therapies?	☐ Yes ☐ No

If yes, please complete below:

Medication Name	Dose/Strength	Frequency

Please be sure to complete and include the 2nd page of this form.

AUBAGIO
Page 2

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form

Is this request for a reauthorization?	☐ **Yes** ☐ **No** **If yes, please include the following documentation:**
☐ **Documentation showing members disease has stabilized**	☐ **Documentation of no active infection**

☐ **Documentation that the member is NOT on concomitant therapy with antineoplastic, immunosuppressive, or immune modulating therapies.**

☐ **Documentation that the member's transaminase/bilirubin levels are being monitored consistently.**

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