UPMC HEALTH PLAN

Cerezyme, Elelyso, & VPRIV

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, 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: Strength:			1:	Frequency:			Qty Di	Qty Dispensed:		
Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.										
☐ New medication☐ Ongoing medicationIf ongoing, provious started:				;						
☐Ongoing medication				Show improve						
Please indicate place of			Physician's Office			se indicate how i				
administration/infusion:			☐H⊗pital/Fac	ility	☐ Billed directly by the provider via JCODE					
Please provide facility/provider name and address:						Provide JCODE:				
Billed by a pharmacy and delivered to								lelivered to the	e provider	
☐ Billed by a pharmacy and delivered to the patient									e patient	
MEDICAL HISTORY										
Does the member have a diagnosis of Gaucher Disease?										
If No, Please provide the diagnosis:										
Does the member have any of the following conditions:										
Thumberton original Culonomorals										
☐ Thrombocytopenia ☐ Splenomegaly										
☐ Anemia ☐ Bone Disease										
☐ Hepatomegaly ☐ Other, Please specify:										
Please list all other medications the member has previously tried or is currently using.										
Medication Name Strength			Frequency		Date	s of Trial	List	List adverse reactions/side		
		8	1 0	Star	Start Date End Date		effects/reason for discontinuation			
				300						
Please provide any additional information which should be considered in the space below:										