

# UPMC Health Plan

## Rescula, Travoprost (Travatan), Travatan Z, Zioptan

### 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.**

*Incomplete responses may delay this request.*

<b>Office contact:</b>		<b>Provider specialty:</b>			
<b>Provider first name</b>		<b>Provider last name:</b>			
<b>Provider phone #:</b>		<b>Provider fax #:</b>			
<b>Patient name:</b>		<b>Patient UPMC Health Plan Member ID #:</b>		<b>Patient DOB:</b>	<b>Patient age:</b>
<b>Drug requested:</b> <input type="checkbox"/> Brand <input type="checkbox"/> Generic		<b>Strength:</b>	<b>Frequency:</b>		<b>Quantity dispensed (including units):</b>
<i>Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.</i>					
<input type="checkbox"/> New medication		<b>If ongoing, please provide start date:</b>		<b>If ongoing, did the member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing medication					
<b>Diagnosis:</b>					
<b>Please indicate place of administration</b>		<input type="checkbox"/> Physician office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient home		<b>Will the medication be (select one):</b>	
<b>Please provide hospital/facility name and address:</b>				<input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____	
				<input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
<b>Medical History</b>					
<b>Has the member previously tried and latanoprost (Xalatan)?</b>					<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, please provide reason for discontinuation:</b>					
<b>Please list all medications the member has previously tried or is currently using.</b>					
<b>Medication Name</b>	<b>Strength</b>	<b>Frequency</b>	<b>Start date</b>	<b>End date</b>	<b>Reason for failure or discontinuation</b>
<b>Please provide any additional information which should be considered in the space below:</b>					