Somavert

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.

Please complete all sections of this form. 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 Age:**	**Patient DOB:**
Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

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**
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:			

Please indicate the diagnosis and answer the corresponding questions:

❑ Acromegaly	Is the medication being prescribed by or in consultation with an endocrinologist? ❑Yes ❑No
	Please provide the member's IGF-1 level:_____ Laboratory reference range:_____ Date of test _____
	Please provide the member's Growth Hormone (GH) level during oral glucose tolerance test_____ Date of Test:_____
	Did the member have an inadequate response to medical therapy (octreotide, Sandostatin Lar, Somatuline Depot)? ❑Yes ❑No If yes, please provide medication name:
	If no, Please provide documentation that these therapies are not appropriate. ☐ Chart documentation enclosed ☐ Chart documentation not available
❑ Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

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