

COUGH AND COLD MEDICATIONS PRIOR AUTHORIZATION FORM (form effective 7/10/2023)

Prior authorization guidelines **Cough and Cold Medications** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1.	For a beneficiary under 18 years of age: <input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to alternative treatments medically accepted for the beneficiary's diagnosis <input type="checkbox"/> If symptoms last longer than 1 week, was evaluated for other diagnoses, such as allergies, bronchitis, pneumonia, etc. <input type="checkbox"/> The requested medication does <u>not</u> contain an opioid
2.	For a Cough and Cold Medication containing promethazine for a beneficiary under 6 years of age: <input type="checkbox"/> Will not be taking the requested Cough and Cold Medication concomitantly with a medication with respiratory depressant effects <input type="checkbox"/> Does not have a contraindication to the requested medication
3.	For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder (OUD) OR Vivitrol (naltrexone extended-release suspension for injection): <input type="checkbox"/> Both prescriptions are prescribed by the same prescriber <input type="checkbox"/> Prescriptions are prescribed by different prescribers and all prescribers are aware of the other prescription(s) <input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to alternative treatments, including non-opioid Cough and Cold Medications, that are medically accepted for the beneficiary's diagnosis <input type="checkbox"/> Not applicable – beneficiary is not taking a buprenorphine agent indicated for the treatment of OUD or Vivitrol

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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