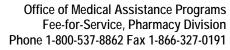


QUANTITY/DAILY DOSE/DURATION LIMITS PRIOR AUTHORIZATION FORM (form effective 01/05/2021)

Prior authorization guidelines for **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.

A list of all quantity limits, daily dose limits, and duration limits is available at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx.

□ New request □ Renewal request	# of pages:	Prescriber name:				
Name of office contact:		Specialty:				
Contact's phone number:		NPI:		State license #:		
LTC facility contact/phone:		Street address:				
Beneficiary name:		Suite #:	City/state/zip:	y/state/zip:		
Beneficiary ID#:	DOB:	Phone:		Fax:		
CLINICAL INFORMATION						
Product requested:			Strength:			
Directions/frequency:			Quantity	<i>t</i> :	Refills:	
Diagnosis (<u>submit documentation</u>):			Dx code	Dx code (required):		
that apply and <u>SUBMIT DOCUMENTATION</u> from the medical record and/or medical literature supporting the rationale for the requested quantity/dose/duration. The beneficiary requires a dose that includes ½ tablets to achieve the total daily dose The dose of the requested medication is being titrated or tapered The beneficiary has a history of intolerance to taking the medication at the FDA-approved frequency of administration The quantity/daily dose/duration are supported by current medical compendia and/or peer-reviewed medical literature Higher strength(s) of the medication are unavailable due a supply issue (e.g., manufacturer backorder or discontinuation)						
Please complete the sections below that apply to the beneficiary and this request. Check all that apply and <u>SUBMIT MEDICAL RECORD</u> <u>DOCUMENTATION</u> supporting each item.						
OPIOID ANALGESICS: Is being treated for moderate pain Is being treated for severe pain Had inadequate pain control at dose/frequency within quantity limits The drug/dose is prescribed by or in consultation with a specialist For short-acting opioids: Cannot use a long-acting opioid analgesic Cannot increase the dose of a currently prescribed long-acting opioid analgesic A long-acting opioid analgesic is not appropriate for the beneficiary Has inadequate pain control with or contraindication/intolerance of other short-acting opioid analgesics						





For long-acting opioids:					
☐ Has inadequate pain control with or contraindication/intolerance of other long-acting opioid analgesics					
☐Dose is being appropriately titrated or converted from other opioid analgesics					
MIGRAINE ACUTE TREATMENT AGENTS:					
The drug/dose is prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties					
If being used for the acute treatment of migraine:					
Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)					
 ☐ Will be using the requested medication with <u>at least one</u> medication for migraine prevention – specify: ☐ anticonvulsant (e.g., topiramate, valproate derivative) ☐ beta blocker (e.g., metoprolol, propranolol, timolol) 					
antidepressant (e.g., SNRI, TCA)	☐CRGP monoclonal antibody (e.g., Aimovig, Emgality)				
Other:					
Tried and failed preventive migraine medications – specify:					
anticonvulsant (e.g., topiramate, valproate derivative)	beta blocker (e.g., metoprolol, propranolol, timolol)				
antidepressant (e.g., SNRI, TCA)	☐CRGP monoclonal antibody (e.g., Aimovig, Emgality)				
other:					
Has an intolerance or a contraindication to preventive migraine medications – specify:					
anticonvulsant (e.g., topiramate, valproate derivative)	beta blocker (e.g., metoprolol, propranolol, timolol)				
antidepressant (e.g., SNRI, TCA)	CRGP monoclonal antibody (e.g., Aimovig, Emgality)				
other:					
INJECTABLE ANTICOAGULANTS:					
Has a medical condition that requires more than 10 days of therapy with an injectable anticoagulant					
Cannot use an oral anticoagulant for the medical condition					
PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO DHS – PHARMACY DIVISION					
Prescriber Signature:	Date [.]				

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