pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	Strength:	
Directions/frequency:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (required):	

What is the medical reason the beneficiary requires the requested medication at a dose that exceeds the quantity limits/daily dose limits? *Check all that apply and SUBMIT DOCUMENTATION 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 SUBMIT MEDICAL RECORD DOCUMENTATION 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

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☐ **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 at least one 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 FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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