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

THERAPEUTIC DUPLICATION PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.).

☐New request ☐Renewal request	total # 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

Current medication requested (that requires prior authorization for therapeutic duplication):		Strength:
Directions:	Quantity:	Refills:
Diagnosis:	Diagnosis code (*required*):	

What other medication(s) in the same drug class/grouping has the beneficiary received from any prescriber in the past 45 days? *Submit documentation of beneficiary's current and recent medications.*

Medication name/strength: _____ Directions: _____ Date last filled: _____

Medication name/strength: _____ Directions: _____ Date last filled: _____

Medication name/strength: _____ Directions: _____ Date last filled: _____

Check all of the following that apply to the beneficiary and this therapeutic duplication request and SUBMIT DOCUMENTATION for each item.

☐The requested medication is replacing another medication (i.e., one of the medications has been discontinued/stopped completely)

☐One of the medications is being tapered with the intent of discontinuation (stopping completely)

Anticipated duration of concurrent use of the duplicate medications: _____

☐Both medications will be used concurrently and:

☐Medical literature supports the concurrent use of these medications. *Submit supporting documentation from the medical literature.*

☐Clinical rationale for concurrent use of these medications: _____

_____

_____

_____

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

Prescriber Signature:	Date: