

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

Prior authorization guidelines and Quantity Limits/Daily Dose Limits: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> 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:	

Please refer to <https://papdl.com/preferred-drug-list> for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:		Dosage form:	Strength:
Directions:		Quantity:	Refills:
Diagnosis <i>(submit documentation)</i> :		DX code <i>(required)</i> :	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*..... Yes No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.

- Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

- Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

- Contraindication to preferred medication(s) *(include description and drug name(s))*:

- Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

- Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

- Drug-drug interaction with preferred medication(s) *(describe)*:

- Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

- For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.

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

Prescriber Signature:	Date:
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