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

POTASSIUM REMOVING AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Potassium Removing Agents** 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.

☐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

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:		Strength/formulation:	
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

Is the medication being prescribed by or in consultation with a cardiologist or nephrologist?	☐Yes	☐No	*Submit documentation.*
INITIAL requests			
Does the beneficiary have a recent serum potassium level(s) consistent with hyperkalemia? Serum potassium: _____ Date obtained: _____ Serum potassium: _____ Date obtained: _____	☐Yes	☐No	*Submit documentation.*
Has the beneficiary tried and failed a low potassium diet?	☐Yes	☐No	*Submit documentation.*
Has the beneficiary tried and failed a loop or thiazide diuretic (if clinically appropriate)? Diuretic(s) tried: _____ Reason diuretics cannot be tried: _____	☐Yes	☐No	*Submit documentation.*
Submit the beneficiary's complete medication list. If the beneficiary is taking any medications that are known to cause hyperkalemia, has the beneficiary tried and failed discontinuation or dose reduction of these medications?	☐Yes	☐No	*Submit documentation.*
For a non-preferred medication: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes	☐No	*Submit documentation.*
RENEWAL requests			
Has the beneficiary experienced a positive clinical response since starting the requested medication? Serum potassium: _____ Date obtained: _____ Serum potassium: _____ Date obtained: _____	☐Yes	☐No	*Submit documentation.*

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

Prescriber Signature:	**Date**: