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

UREA CYCLE DISORDER AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Urea Cycle Disorder 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 metabolic disorders specialist? ☐Yes ☐No *Submit documentation of consultation.*

INITIAL requests

Is the beneficiary's diagnosis supported by any of the following? *Check all that apply.*

☐ammonia levels
☐enzyme assays
☐genetic testing
☐plasma amino acid/urine orotic acid analyses
☐progress notes
☐other *(specify)*: _____

☐Yes ☐No *Submit documentation.*

Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medication in this class? *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? ☐Yes ☐No *Submit documentation.*

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

Prescriber Signature:	**Date**: