

TEKTURNA/TEKTURNA HCT 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.). To review the prior authorization guidelines for Angiotensin Modulators, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Angiotensin Modulators (accessible at: <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

PRESCRIBER INFORMATION

New Renewal Additional info. (PA#: _____)
 Number of pages in this request: _____
 Name of office contact: _____
 Contact's phone number: _____
 Long-Term Care contact/phone: _____

Prescriber name: _____
 Specialty: _____ State license #: _____
 NPI: _____ -OR- MA Provider ID#: _____
 Street address: _____
 Suite #: _____ City/state/zip: _____
 Phone: _____ Fax: _____

RECIPIENT INFORMATION

Recipient Name: _____
 Recipient ID#: _____ DOB: _____

CLINICAL INFORMATION

Medication requested: _____ Strength: _____ Qty: _____ Refills: _____
 Directions: _____ Diagnosis: _____ Dx code: _____ (required)

ALL requests:

1. Is the Recipient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the Recipient have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Will the Recipient be taking any of the following medications in addition to the requested medication? <u>Submit documentation of Recipient's full current medication list.</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> an ACE inhibitor <input type="checkbox"/> cyclosporine <input type="checkbox"/> itraconazole <input type="checkbox"/> an ARB <input type="checkbox"/> high-dose diuretics	
4. Does the Recipient have a history of a hypersensitivity reaction to an ACE inhibitor or ARB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Complete <i>INITIAL</i> or <i>RENEWAL</i> section below.	

INITIAL requests:

1. Does the Recipient have a contraindication or intolerance to, or has the Recipient tried and failed drugs from the following drug classes, taken at maximally-tolerated FDA-approved doses? <input type="checkbox"/> ACE inhibitors <input type="checkbox"/> Angiotensin receptor blockers (ARBs) <input type="checkbox"/> beta-blockers <input type="checkbox"/> calcium-channel blockers <input type="checkbox"/> diuretics	<input type="checkbox"/> Yes – <u>submit documentation</u> <input type="checkbox"/> No
2. Were other causes of hypertension ruled out, including the following: <input type="checkbox"/> Cushing's syndrome <input type="checkbox"/> hyperaldosteronism <input type="checkbox"/> pheochromocytoma <input type="checkbox"/> renal artery stenosis	<input type="checkbox"/> Yes – <u>submit documentation</u> <input type="checkbox"/> No
3. Does the Recipient have results of baseline electrolyte and kidney function tests?	<input type="checkbox"/> Yes – <u>submit results</u> <input type="checkbox"/> No

RENEWAL requests:

1. Does the Recipient have results of recent (since starting therapy) electrolyte and kidney function tests?	<input type="checkbox"/> Yes – <u>submit results</u> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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