

METHOTREXATE AGENTS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Methotrexate Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Methotrexate** (accessible at:

<http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

<u>Non-preferred medication requested:</u> <input type="checkbox"/> Otrexup injection <input type="checkbox"/> Rheumatrex tablet <input type="checkbox"/> Rasuvo injection <input type="checkbox"/> Trexall tablet			
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code (required):	
1. Has the Recipient tried and failed the following preferred Methotrexate Agents? <input type="checkbox"/> methotrexate injection <input type="checkbox"/> methotrexate preservative-free injection <input type="checkbox"/> methotrexate tablet			<input type="checkbox"/> Yes – <u>submit documentation of treatment regimen tried & failed</u> <input type="checkbox"/> No
2. Does the Recipient have an intolerance or contraindication to the preferred Methotrexate Agents listed in question (1)?			<input type="checkbox"/> Yes – <u>submit documentation of intolerances or contraindications</u> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
-----------------------	-------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.