

PRENATAL VITAMINS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Prenatal Vitamins, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Prenatal Vitamins** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA#: _____)	_____			
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

Non-preferred medication requested		
<input type="checkbox"/> Completenate chewable <input type="checkbox"/> Focalgin CA Combo Pack <input type="checkbox"/> Focalgin 90 DHA Combo Pack <input type="checkbox"/> Folivane-OB capsule <input type="checkbox"/> Nexa Plus softgel <input type="checkbox"/> Niva-Plus tablet <input type="checkbox"/> OB Complete caplet	<input type="checkbox"/> OB Complete + DHA softgel <input type="checkbox"/> OB Complete One softgel <input type="checkbox"/> OB Complete Petite softgel <input type="checkbox"/> OB Complete Premier tablet <input type="checkbox"/> O-Cal FA tablet <input type="checkbox"/> PNV 29-1 mg tablet. <input type="checkbox"/> Provida OB capsule	<input type="checkbox"/> Provida DHA capsule <input type="checkbox"/> Taron-C DHA capsule <input type="checkbox"/> Taron-Prex Prenatal DHA capsule <input type="checkbox"/> Triveen-Duo DHA combo pak <input type="checkbox"/> Ultimatecare One capsule <input type="checkbox"/> Virtprex capsule <input type="checkbox"/> _____
Directions: _____		Quantity: _____ Refills: _____
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):
1. Has the Recipient tried and failed any of the preferred Prenatal Vitamins? <i>Check all that apply.</i> <input type="checkbox"/> Complete Natal DHA capsule <input type="checkbox"/> Pretab 29-1 tablet <input type="checkbox"/> Virt-Nate tablet <input type="checkbox"/> Dothelle DHA softgel <input type="checkbox"/> Rulavite DHA softgel <input type="checkbox"/> Virt-Nate DHA softgel <input type="checkbox"/> Elite-OB caplet <input type="checkbox"/> Trinatal Rx 1 tablet <input type="checkbox"/> Virt-PN DHA softgel <input type="checkbox"/> Preplus Ca-Fe-FA tablet <input type="checkbox"/> Virt-Advance tablet <input type="checkbox"/> Virt-PN tablet		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure.</i> <input type="checkbox"/> No
2. Does the Recipient have any contraindications or intolerances to the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances and contraindications.</i> <input type="checkbox"/> No

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

Prescriber Signature: _____	Date: _____
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