

**VECAMYL (mecamylamine) PRIOR AUTHORIZATION FORM**

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Vecamyl** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION 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**

<b>Medication:</b> <input type="checkbox"/> Vecamyl 2.5 mg tablet	<b>Directions:</b>	<b>Quantity:</b>	<b>Refills:</b>
<b>Diagnosis:</b>		<b>Dx code (required):</b>	

**INITIAL REQUESTS**

1. Is Vecamyl being prescribed by or in consultation with a hypertension specialist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of consultation with specialist, if applicable.</i>
2. Does the Recipient have a diagnosis of severe essential (primary) hypertension or uncomplicated malignant hypertension?	<input type="checkbox"/> Yes – <i>submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>submit medical literature supporting the use of Vecamyl for the Recipient's diagnosis.</i>	
3. Does the Recipient have any of the following contraindications to Vecamyl? <i>Check all that apply.</i> <input type="checkbox"/> mild, moderate, or labile hypertension <input type="checkbox"/> heart disease (CAD or coronary insufficiency) <input type="checkbox"/> recent myocardial infarction (MI) <input type="checkbox"/> renal impairment <input type="checkbox"/> glaucoma <input type="checkbox"/> pyloric stenosis <input type="checkbox"/> currently taking antibiotics or sulfonamides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation, including lab results, current medication list, etc.</i>
4. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following first- and second-line antihypertensive drug classes at maximal tolerated doses? <i>Check all that apply.</i> <input type="checkbox"/> ACE inhibitor (ex. lisinopril, enalapril, ramipril, captopril) <input type="checkbox"/> angiotensin receptor blocker (ARB) (ex. losartan, valsartan, irbesartan) <input type="checkbox"/> calcium channel blocker (CCB) (ex. amlodipine, diltiazem, nifedipine) <input type="checkbox"/> thiazide diuretic (ex. hydrochlorothiazide, chlorthalidone, indapamide)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and treatment outcomes or contraindications/intolerances.</i>

**RENEWAL REQUESTS**

1. Has the Recipient experienced an improvement in blood pressure since starting Vecamyl?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of Recipient's blood pressure response.</i>
2. Does the Recipient have any of the following contraindications to Vecamyl? <i>Check all that apply.</i> <input type="checkbox"/> mild, moderate, or labile hypertension <input type="checkbox"/> heart disease (CAD or coronary insufficiency) <input type="checkbox"/> recent myocardial infarction (MI) <input type="checkbox"/> renal impairment <input type="checkbox"/> glaucoma <input type="checkbox"/> pyloric stenosis <input type="checkbox"/> currently taking antibiotics or sulfonamides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation, including lab results, current medication list, etc.</i>

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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