

## THERAPEUTIC DUPLICATION 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.).

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

1. Current Medication Requested (that is rejecting for therapeutic duplication):		Strength:	
(cont') Directions:		Quantity:	Refills:
(cont') Diagnosis:		Diagnosis code (required):	
2. What type of medication is the rejecting medication? <i>Choose drug class/grouping from the list below.</i> (See the Department's Covered Drug Search tool at the following link to determine which drug class/grouping applies: <a href="http://www.dhs.pa.gov/provider/pharmacyservices/covereddrugs/index.htm">http://www.dhs.pa.gov/provider/pharmacyservices/covereddrugs/index.htm</a> .)			
<input type="checkbox"/> Angiotensin Modulators	<input type="checkbox"/> Antipsychotics, Typical	<input type="checkbox"/> Calcium Channel Blockers	<input type="checkbox"/> Narcotics, Short-Acting
<input type="checkbox"/> Alzheimer's Agents	<input type="checkbox"/> Benzodiazepines, Long-Acting	<input type="checkbox"/> COPD Agents	<input type="checkbox"/> NSAIDs
<input type="checkbox"/> Androgenic Agents	<input type="checkbox"/> Benzodiazepines, Short-Acting	<input type="checkbox"/> Gabapentin & Lyrica (pregabalin)	<input type="checkbox"/> Proton Pump Inhibitors
<input type="checkbox"/> Anticoagulants, Injectable	<input type="checkbox"/> Beta Agonists, Long-Acting	<input type="checkbox"/> HIV Agents, NNRTI	<input type="checkbox"/> Skeletal Muscle Relaxants
<input type="checkbox"/> Anticoagulants, Oral	<input type="checkbox"/> Beta Agonists, Short-Acting	<input type="checkbox"/> HIV Agents, Protease Inhibitors	<input type="checkbox"/> Statins (Lipotropics, Statins)
<input type="checkbox"/> Antidepressants, SSRIs	<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> Inhaled Glucocorticoids	<input type="checkbox"/> Stimulants, Long-Acting
<input type="checkbox"/> Antihistamines, Minimally Sedating	<input type="checkbox"/> Bladder Relaxants	<input type="checkbox"/> Leukotriene Modifiers	<input type="checkbox"/> Stimulants, Short-Acting
<input type="checkbox"/> Antipsychotics, Atypical	<input type="checkbox"/> BPH Agents	<input type="checkbox"/> Narcotics, Long-Acting	<input type="checkbox"/> Triptans (Antimigraine, Triptans)
3. What other medication(s) in the <b>same drug class/grouping</b> has the Recipient received from any prescriber in the <b>past 45 days</b> ? <b>List all applicable medications, including strength, directions, and last fill for each.</b> <i>Submit documentation of Recipient's current and recent medications.</i>			
[1] Medication name/strength/directions/date of last fill:			
[2] Medication name/strength/directions/date of last fill:			
[3] Medication name/strength/directions/date of last fill:			
4. Is the medication requested in question (1) replacing the medication in question (3) [ie, medication in question (3) has been stopped completely]?		<input type="checkbox"/> Yes – <i>include medical record documentation of discontinuation of the duplicate drug in question (3) and fax request to the Department</i> <input type="checkbox"/> No – continue to next question	
5. Is the medication in question (3) going to be discontinued or tapered (dose slowly decreased) with a goal of stopping it completely?		<input type="checkbox"/> Yes – <i>include medical record documentation of plan for discontinuation or taper and fax request to the Department</i> <input type="checkbox"/> No – continue to next question	
6. If both medications in questions (1) and (3) will be taken together, is there medical literature or national treatment guidelines to support the concurrent use of both medications?		<input type="checkbox"/> Yes – <i>include documentation of supporting literature/guidelines</i> <input type="checkbox"/> No – continue to next question	
7. What is the clinical reason for using both medications together?			

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

Prescriber Signature:	Date:
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