

**ANXIOLYTICS**  
**PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for these agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Anxiolytics (accessible at: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>).

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information

**For Additional Information:** Coordinator Name: \_\_\_\_\_ PA#: \_\_\_\_\_

Number of Pages in this Request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ & Phone: (\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

**Non-Preferred Agents:**  alprazolam ODT tablet     alprazolam ER tablet     alprazolam intensol     Ativan tablet\*  
 diazepam intensol     diazepam injection syringe     meprobamate tablet     Niravam ODT     oxazepam capsule  
 Tranxene T-tab\*     Valium tablet\*     Xanax tablet\*     Xanax XR tablet\*

*\*Also requires prior authorization for use as a "Brand Medically Necessary" agent – please complete Question (4)*

**Strength:** \_\_\_\_\_ **Directions:** \_\_\_\_\_ **Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Diagnosis Code:** \_\_\_\_\_ (Required)

**1. Has the Recipient tried and failed any of the preferred Anxiolytic agents?**

Yes (check all that apply and submit documentation)       No

- alprazolam tablet
- buspirone tablet
- chlordiazepoxide capsule
- clorazepate tablet
- diazepam tablet, oral solution or injection vial
- lorazepam tablet or intensol

**2. Does the Recipient have contraindications or intolerances to any of the preferred agents listed in question (1)?**

Yes (submit documentation)       No

**3. Does the request exceed the Quantity Limit (a link to the Quantity Limit list is at the bottom of this section):**

Yes (submit documentation supporting prescribed quantity)       No

**4. Is the request for a "Brand Name Medically Necessary" agent?**

Yes (submit documentation showing why the generic formulation cannot be used)       No

**Quantity Limit List:** <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>

**PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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