

GLUCOCORTICOIDS, INHALED 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.).

To review the prior authorization guidelines for Glucocorticoids, Inhaled, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Glucocorticoids, Inhaled** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

Refer to the list of **quantity limits** at <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>.

PRIOR AUTHORIZATION 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

Non-preferred medication requested: <div style="display: flex; justify-content: space-between; padding: 5px;"> <div style="width: 24%;"> <input type="checkbox"/> Advair HFA <input type="checkbox"/> Alvesco <input type="checkbox"/> Arnuity Ellipta </div> <div style="width: 24%;"> <input type="checkbox"/> Asmanex HFA <input type="checkbox"/> Breo Ellipta <input type="checkbox"/> budesonide respules </div> <div style="width: 24%;"> <input type="checkbox"/> Flovent Diskus <input type="checkbox"/> Pulmicort Flexhaler <input type="checkbox"/> Pulmicort Respules </div> </div>			
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Diagnosis code (<i>required</i>):	
1. Has the Recipient tried and failed the preferred Inhaled Glucocorticoids? <i>Check all that apply.</i> <input type="checkbox"/> Advair Diskus <input type="checkbox"/> Dulera <input type="checkbox"/> QVAR <input type="checkbox"/> Aerospa <input type="checkbox"/> Flovent HFA <input type="checkbox"/> Symbicort <input type="checkbox"/> Asmanex Twistihaler		<input type="checkbox"/> Yes <u>Submit medical record documentation of Recipient's medication regimen and response to treatment</u> <input type="checkbox"/> No	
2. Does the Recipient have a contraindication or intolerance to any of the preferred Inhaled Glucocorticoids listed in question (1)?		<input type="checkbox"/> Yes <u>Submit medical record documentation of contraindications/intolerances</u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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