pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

Prior authorization guidelines and **Quantity Limits/Daily Dose Limits:** https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:	Dosage form:	Strength:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*.............................. ☐Yes ☐No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. ***Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.***

☐Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

☐Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

☐Contraindication to preferred medication(s) *(include description and drug name(s))*:

☐Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

☐Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

☐Drug-drug interaction with preferred medication(s) *(describe)*:

☐Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

☐**For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.**

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

Prescriber Signature:	**Date:**

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