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

ANTIPARKINSON'S AGENTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Antiparkinson's Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐amantadine tablet
☐Azilect tablet
☐carbidopa tablet
☐carbidopa/levodopa ODT
☐Comtan tablet
☐Duopa suspension
☐entacapone tablet
☐Gocovri capsule
☐Lodosyn tablet
☐Mirapex tablet
☐Mirapex ER tablet
☐Neupro patch
☐Osmolex ER tablet
☐Parlodel capsule
☐Parlodel tablet
☐pramipexole ER tablet
☐rasagiline tablet
☐Requip tablet
☐Requip XL tablet
☐ropinirole ER tablet
☐Rytary ER capsule
☐Sinemet tablet
☐Sinemet CR tablet
☐Stalevo tablet
☐Tasmar tablet
☐tolcapone tablet
☐Xadago tablet
☐Zelapar ODT
☐_____
_____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*:

Dx code (*required*):

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antiparkinson's Agents? *Check all that apply.*

☐amantadine capsule or solution
☐benztropine tablet
☐bromocriptine capsule or tablet
☐carbidopa/levodopa IR or ER tablet
☐carbidopa/levodopa/entacapone tablet
☐pramipexole IR tablet
☐ropinirole IR tablet
☐selegiline capsule or tablet
☐trihexyphenidyl elixir or tablet

☐Yes – *Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.*

☐No

2. Has the beneficiary taken the requested non-preferred medication in the past 90 days?

☐Yes – *Submit documentation of drug regimen and clinical response.*
☐No

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

Prescriber Signature:	**Date**: