

ANTIPSORIATICS, ORAL PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antipsoriatics, Oral agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antipsoriatics, Oral** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list 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# _____)	# 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:				<input type="checkbox"/> acitretin capsule	<input type="checkbox"/> Oxisoralen-Ultra soft gelatin capsule
				<input type="checkbox"/> methoxsalen rapid capsule	
Strength:	Dose/directions:	Quantity:	Refills:		
Diagnosis (<i>submit documentation</i>):				Dx code (<i>required</i>):	
1. Antipsoriatics, Oral agents are included in the Department's Specialty Pharmacy Drug Program (SPDP) . What Specialty Pharmacy will be used? Refer to the Department's SPDP website for more information: http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm .				<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy	
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Antipsoriatic, Oral agents? <i>Check all that apply.</i>				<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No	
<input type="checkbox"/> 8-MOP hard gelatin capsule <input type="checkbox"/> Soriatane capsule					

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

Prescriber Signature:	Date:
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