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

ANTIPSORIATICS, TOPICAL 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 Topical Antipsoriatics, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antipsoriatics, Topical** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	Total # 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:

☐calcipotriene 0.005% cream
☐calcipotriene 0.005% ointment
☐calcipotriene/betamethasone ointment
☐calcitrene ointment
☐calcitriol 3 mcg/gm ointment
☐Enstilar foam
☐Sorilux foam
☐Taclonex suspension
☐Taclonex ointment
☐Tazorac cream
☐Tazorac gel
☐tazarotene cream
☐Vectical ointment
☐_____

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 Topical Antipsoriatics? *Check all that apply.*

☐calcipotriene 0.005% scalp solution
☐Dovonex cream

☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

☐No

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

Prescriber Signature:	**Date**: