

EPINEPHRINE, SELF-INJECTED PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Self-Injected Epinephrine products, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Epinephrine, Self-Injected** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:		
<input type="checkbox"/> Renewal request	(PA# _____)	_____			
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"/> Adrenaclick 0.15 mg auto-injector	<input type="checkbox"/> Adrenaclick 0.3 mg auto-injector
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
1. Has the Recipient tried and failed any of the preferred Self-Injected Epinephrine products? <i>Check all that apply.</i> <input type="checkbox"/> epinephrine 0.3 mg or 0.15 mg auto-injector (<i>generic Adrenaclick</i>) <input type="checkbox"/> EpiPen 0.3 mg or EpiPen Jr. 0.15 mg auto-injector	<input type="checkbox"/> Yes – <u>Submit all supporting documentation of drug regimen tried and treatment outcomes.</u> <input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to any of the preferred Self-Injected Epinephrine products listed in question (1)?	<input type="checkbox"/> Yes – <u>Submit all supporting documentation of medication name and associated intolerances and contraindications.</u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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