

## HYPOGLYCEMICS, SULFONYLUREAS 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 Sulfonylureas, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Hypoglycemics, Sulfonylureas** (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

<b>Non-preferred medication requested:</b>	<input type="checkbox"/> Amaryl tablet	<input type="checkbox"/> Glucotrol tablet	<input type="checkbox"/> tolbutamide tablet
	<input type="checkbox"/> chlorpropamide tablet	<input type="checkbox"/> Glucotrol XL tablet	<input type="checkbox"/> tolazamide tablet
	<input type="checkbox"/> Diabeta tablet	<input type="checkbox"/> Glynase Prestab	
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Sulfonylureas? <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"/> glimepiride tablet	<input type="checkbox"/> glyburide (generic Diabeta) tablet		
<input type="checkbox"/> glipizide tablet	<input type="checkbox"/> glyburide, micronized (generic Glynase) tablet		
<input type="checkbox"/> glipizide ER/XL tablet			

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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