

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS 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 Ophthalmics for Allergic Conjunctivitis, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Ophthalmics for Allergic Conjunctivitis** (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 (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"/> Alocril drops	<input type="checkbox"/> Elestat drops	<input type="checkbox"/> Pataday <u>0.2%</u> drops
	<input type="checkbox"/> Alomide drops	<input type="checkbox"/> Emadine drops	<input type="checkbox"/> Patanol <u>0.1%</u> drops
	<input type="checkbox"/> azelastine 0.05% drops (<i>Optivar</i>)	<input type="checkbox"/> epinastine drops (<i>Elastat</i>)	<input type="checkbox"/> Pazeo <u>0.7%</u> drops
	<input type="checkbox"/> Bepreve drops	<input type="checkbox"/> Lastacraft drops	
<i>NOTE: Brand names, where applicable, are listed in italics for reference purposes.</i>			
Directions:	Quantity:	Refills:	
Diagnosis (<u>submit documentation</u>):	Dx code (<u>required</u>):		
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Ophthalmics for Allergic Conjunctivitis? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</u> <input type="checkbox"/> No	
<input type="checkbox"/> Alrex drops	<input type="checkbox"/> Naphcon-A drops (OTC)		
<input type="checkbox"/> cromolyn 4% drops	<input type="checkbox"/> olopatadine <u>0.1%</u> drops (<i>Patanol</i>)		
<input type="checkbox"/> ketotifen 0.025% drops (OTC)	<input type="checkbox"/> Zaditor drops (OTC)		

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

Prescriber Signature:	Date:
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