

OPHTHALMICS, GLAUCOMA AGENTS 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, Glaucoma Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Ophthalmics, Glaucoma Agents** (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"/> Betagan drops <input type="checkbox"/> betaxolol 0.5% drops (<i>Betoptic</i>) <input type="checkbox"/> bimatoprost 0.03% drops (<i>Lumigan 0.03%</i>) <input type="checkbox"/> brimonidine-P 0.15% drops (<i>Alphagan-P 0.15%</i>) <input type="checkbox"/> Cosopt PF drops <input type="checkbox"/> Cosopt drops <input type="checkbox"/> lopiclone 0.5% drops <input type="checkbox"/> lopiclone 1% drops	<input type="checkbox"/> Isopto Carpine drops <input type="checkbox"/> Istalol drops <input type="checkbox"/> Lumigan 0.01% drops <input type="checkbox"/> phospholine iodide 0.125% drops <input type="checkbox"/> Simbrinza drops <input type="checkbox"/> timolol 0.25% and 0.5% gel-forming solution	<input type="checkbox"/> Timoptic <i>Ocudose</i> drops <input type="checkbox"/> Timoptic XE gel-forming sol'n <input type="checkbox"/> travoprost 0.004% drops (<i>Travatan Z</i>) <input type="checkbox"/> Trusopt drops <input type="checkbox"/> Xalatan drops <input type="checkbox"/> Zioptan drops
NOTE: Brand names, where applicable, are listed in italics for reference purposes only. These brand name agents may or may not still be available in the marketplace.			
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 Ophthalmics, Glaucoma Agents? <i>Check all that apply.</i> <input type="checkbox"/> Alphagan-P 0.1% drops <input type="checkbox"/> Alphagan-P 0.15% drops <input type="checkbox"/> apraclonidine 0.5% drops (<i>lopiclone 0.5%</i>) <input type="checkbox"/> Azopt drops <input type="checkbox"/> Betoptic-S 0.25% drops <input type="checkbox"/> brimonidine 0.2% drops (<i>Alphagan</i>) <input type="checkbox"/> carteolol 1% drops (<i>Ocupress</i>) <input type="checkbox"/> Combigan drops <input type="checkbox"/> dorzolamide 2% drops (<i>Trusopt</i>) <input type="checkbox"/> dorzolamide/timolol drops (<i>Cosopt</i>) <input type="checkbox"/> latanoprost 0.005% drops (<i>Xalatan</i>) <input type="checkbox"/> levobunolol 0.5% drops (<i>Betagan</i>) <input type="checkbox"/> pilocarpine drops (<i>Isopto Carpine</i>) <input type="checkbox"/> timolol 0.25% and 0.5% drops (<i>Timoptic</i>) <input type="checkbox"/> Timoptic 0.25% and 0.5% drops <input type="checkbox"/> Travatan Z drops		<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	

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

Prescriber Signature:	Date:
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