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

BLADDER RELAXANTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Bladder Relaxants** and **Quantity Limits/Daily Dose Limits,** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/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#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐darifenacin ER tablet
☐Detrol tablet
☐Detrol LA capsule
☐Ditropan XL tablet
☐Enablex ER tablet
☐flavoxate tablet
☐Gelnique gel
☐Myrbetriq ER tablet
☐Oxytrol Rx patch
☐tolterodine tablet
☐tolterodine ER capsule
☐trospium tablet
☐trospium ER capsule
☐_____
_____

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Bladder Relaxants? *Check all that apply.*

   ☐oxybutynin syrup or tablet
   ☐oxybutynin ER tablet
   ☐Oxytrol for Women OTC patch
   ☐Toviaz ER tablet
   ☐Vesicare tablet

   ☐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**: