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

METHOTREXATE PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Methotrexate** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST 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#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	☐Otrexup injection ☐Rasuvo injection	☐Trexall tablet ☐_____	
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code *(required)*:	
1. Has the beneficiary tried and failed the following preferred Methotrexate agents? ☐methotrexate injection ☐methotrexate preservative-free injection ☐methotrexate tablet		☐Yes – *Submit documentation of treatment regimen tried and failed.* ☐No	
2. Does the beneficiary have an intolerance or contraindication to the preferred Methotrexate agents listed in question (1)?		☐Yes – *Submit documentation of intolerances or contraindications.* ☐No	

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

Prescriber Signature:	**Date**: