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

ALISKIREN AGENTS (Tekturna/Tekturna HCT) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Angiotensin Modulators (including aliskiren agents)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization.

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:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Tekturna (aliskiren) ☐Tekturna HCT (aliskiren/HCTZ) ☐_____

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Will the beneficiary be taking any of the following medications <u>in addition to</u> the requested medication? *Check all that apply.* ☐an ACE inhibitor (e.g, benazepril, enalapril, lisinopril, quinapril, etc.) ☐angiotensin II receptor blocker (ARB) (e.g., irbesartan, losartan, valsartan, etc.)	☐Yes ☐No *Submit documentation of beneficiary's complete current medication list.*
2. ***<u>For INITIAL requests only</u>:*** Does the beneficiary have a contraindication or intolerance to, or has the beneficiary tried and failed, drugs from the following drug classes, taken at maximally-tolerated FDA-approved doses? *Check all that apply.* ☐ACE inhibitors (e.g, benazepril, enalapril, lisinopril, quinapril, etc.) ☐angiotensin II receptor blockers (ARBs) (e.g., losartan, valsartan, etc.) ☐beta blockers (e.g., atenolol, bisoprolol, carvedilol, metoprolol, etc.) ☐calcium channel blockers (e.g., amlodipine, felodipine, etc.) ☐diuretics (e.g., hydrochlorothiazide)	☐Yes ☐No *Submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcomes.*

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: