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**

# THYROID HORMONES PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Thyroid Hormones, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Thyroid Hormones** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).
- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**

| **PRIOR AUTHORIZATION REQUEST INFORMATION** | | **PRESCRIBER INFORMATION** | |
|---|---|---|---|
| ☐New request ☐Renewal request ☐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:**

☐levothyroxine injection vial ☐liothyronine injection vial ☐Thyrolar tablet ☐Triostat injection vial
☐Levoxyl tablet ☐Synthroid tablet ☐Tirosint capsule ☐Unithroid tablet
☐liothyronine tablet ☐_____

| Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|

| | |
|---|---|
| Diagnosis *(submit documentation)*: | Dx code (*required*): |
| 1. Has the Recipient tried and failed any of the preferred Thyroid Hormones? *Check all that apply.*<br>☐Armour Thyroid tablet<br>☐Cytomel tablet<br>☐levothyroxine tablet | ☐Yes – *submit all supporting documentation of drug regimen and therapeutic failure.*<br>☐No |
| 2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)? | ☐Yes – *submit all supporting documentation of medication name(s) and associated intolerances and contraindications.*<br>☐No |

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

| **Prescriber Signature:** | **Date**: |
|---|---|

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