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

GLUCOCORTICOIDS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Glucocorticoids, Oral** and **Quantity Limits/Daily Dose Limits** are on the DHS Pharmacy Services website available at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/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#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Cortef tablet
☐cortisone tablet
☐DexPak TaperPak
☐Emflaza suspension
☐Emflaza tablet
☐Entocort EC ***(go to question 2)***
☐Medrol tablet
☐Medrol Dosepak
☐Millipred Dosepak
☐Millipred tablet
☐Millipred 10 mg/5 ml solution
☐Orapred ODT
☐prednisolone sodium phosphate ODT
☐prednisone intensol 5 mg/ml
☐Rayos DR tablet
☐Taperdex dose pack
☐Veripred 20 mg/5 ml solution
☐_____

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

1. Does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Glucocorticoids, Oral agents? *Check all that apply.*

☐dexamethasone 0.5 mg/5 ml elixir or solution
☐dexamethasone intensol 1 mg/ml
☐dexamethasone tablet
☐hydrocortisone tablet
☐methylprednisolone tablet or dosepak
☐prednisolone 15 mg/5 ml syrup
☐prednisolone sodium phosphate solution
☐prednisone 5 mg/5 ml solution
☐prednisone tablet or dosepak

☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

☐No

2. ***For requests for Entocort EC capsule***, does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred generic alternative, **budesonide EC capsule**?

☐Yes – *Submit documentation.*
☐No

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

Prescriber Signature:	**Date**: