

GLUCOCORTICOIDS, ORAL PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Glucocorticoids, Oral agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Glucocorticoids, Oral** (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 list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> 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:	<input type="checkbox"/> Cortef tablet <input type="checkbox"/> cortisone tablet <input type="checkbox"/> dexamethasone 0.5 mg/5 ml elixir <input type="checkbox"/> dexamethasone intensol 1 mg/ml <input type="checkbox"/> DexPak TaperPak <input type="checkbox"/> Entocort EC (go to question 2)	<input type="checkbox"/> Medrol tablet <input type="checkbox"/> Medrol Dosepak <input type="checkbox"/> methylprednisolone 8 mg tablet <input type="checkbox"/> methylprednisolone 16 mg tablet <input type="checkbox"/> Millipred tablet <input type="checkbox"/> Millipred 10 mg/5 ml solution	<input type="checkbox"/> Orapred ODT <input type="checkbox"/> Pediapred 5 mg/5 ml solution <input type="checkbox"/> prednisone intensol 5 mg/ml <input type="checkbox"/> prednisolone sodium phosphate ODT <input type="checkbox"/> Rayos tablet <input type="checkbox"/> Veripred 20 mg/5 ml solution
Strength & dosage form:	Dose/directions:		
Quantity:	Refills:	Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Glucocorticoids, Oral agents? <i>Check all that apply.</i>			<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</u> <input type="checkbox"/> No
<input type="checkbox"/> dexamethasone tablet <input type="checkbox"/> dexamethasone 0.5 mg/5 ml solution <input type="checkbox"/> hydrocortisone tablet <input type="checkbox"/> methylprednisolone 4 mg tablet, 32 mg tablet, or dosepak	<input type="checkbox"/> prednisolone 15 mg/5 ml solution <input type="checkbox"/> prednisolone sodium phosphate 5 mg/5 ml, 10 mg/5 ml, 15 mg/5 ml, or 25 mg/5 ml solution <input type="checkbox"/> prednisone tablet or dosepak <input type="checkbox"/> prednisone 5 mg/5 ml solution		
2. <u>For requests for Entocort EC capsule</u> , does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred generic alternative, budesonide EC capsule ?			<input type="checkbox"/> Yes – <u>submit documentation</u> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
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