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

PROGESTATIONAL AGENTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Progestational Agents** 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 INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	total # of pgs: _____	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:
☐Aygestin tablet ☐hydroxyprogesterone caproate vial ☐Provera tablet
☐Crinone vaginal gel ☐Prometrium capsule ☐_____

For Makena requests, please use the "Makena (Hydroxyprogesterone Caproate) Form".

Strength:	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 Progestational Agents? *Check all that apply.*
   - ☐Depo-Provera 400 mg/ml injection
   - ☐medroxyprogesterone acetate tablet
   - ☐norethindrone acetate tablet
   - ☐progesterone capsule
   - ☐progesterone injection

☐Yes – *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.*

☐No

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

Prescriber Signature:	**Date**: