

PROGESTATIONAL AGENTS 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 Progestational Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Progestational Agents** (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"/> Aygestin tablet	<input type="checkbox"/> Depo-Provera <u>400 mg/ml</u> injection	<input type="checkbox"/> Prometrium capsule
	<input type="checkbox"/> Crinone vaginal gel	<input type="checkbox"/> progesterone injection	<input type="checkbox"/> Provera tablet
For Makena requests, please use the "Makena Form".			
Strength:	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 Progestational Agents? <i>Check all that apply.</i> <input type="checkbox"/> medroxyprogesterone acetate tablet <input type="checkbox"/> norethindrone acetate tablet <input type="checkbox"/> progesterone capsule		<input type="checkbox"/> Yes – <u><i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i></u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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