

ULCERATIVE COLITIS 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 Ulcerative Colitis Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Ulcerative Colitis 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	# of pages in request: _____	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA# _____)			
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"/> Asacol HD tablet	<input type="checkbox"/> Dipentum capsule	<input type="checkbox"/> Pentasa capsule	
	<input type="checkbox"/> Azulfidine tablet	<input type="checkbox"/> Giaso tablet	<input type="checkbox"/> Sfrowasa rectal enema	
	<input type="checkbox"/> Azulfidine EN-tab	<input type="checkbox"/> Lialda DR tablet	<input type="checkbox"/> Uceris ER tablet	
	<input type="checkbox"/> balsalazide capsule	<input type="checkbox"/> mesalamine rectal enema	_____	
	<input type="checkbox"/> Colazal capsule	<input type="checkbox"/> mesalamine rectal enema kit	_____	
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 Ulcerative Colitis Agents? <i>Check all that apply.</i>			<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No	
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Mesalamine agents <input type="checkbox"/> Apriso ER capsule <input type="checkbox"/> Canasa rectal suppository <input type="checkbox"/> Delzicol DR capsule </td> <td style="width: 50%; vertical-align: top;"> Sulfasalazine agents <input type="checkbox"/> Sulfazine tablet <input type="checkbox"/> Sulfazine EC tablet <input type="checkbox"/> sulfasalazine tablet <input type="checkbox"/> sulfasalazine DR tablet </td> </tr> </table>				Mesalamine agents <input type="checkbox"/> Apriso ER capsule <input type="checkbox"/> Canasa rectal suppository <input type="checkbox"/> Delzicol DR capsule
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2. <i>For Uceris ER tablet only</i> , does the Recipient have a history of trial and failure, contraindication, or intolerance of other oral corticosteroids (e.g., prednisone, prednisolone, etc.) for the treatment of ulcerative colitis?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of oral corticosteroid agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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