

BPH TREATMENTS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for BPH treatments, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Benign Prostatic Hyperplasia (BPH) Treatment**
(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
(list of limits accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		<input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> # of pages in request: _____	
Name of office contact:		Prescriber name:	
Contact's phone number:		Specialty:	
LTC facility contact/phone:		State license #:	
		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"/> Avodart <input type="checkbox"/> Cardura	<input type="checkbox"/> Cardura XL <input type="checkbox"/> Cialis	<input type="checkbox"/> dutasteride/tamsulosin <input type="checkbox"/> Flomax	<input type="checkbox"/> Jalyn <input type="checkbox"/> Proscar	<input type="checkbox"/> Rapaflo <input type="checkbox"/> Uroxatral
Directions:			Quantity:	Refills:				
Diagnosis:			Diagnosis code (required):					
<u>SECTION A: ALL REQUESTS</u>								
1. Has the Recipient tried and failed the preferred BPH agents? <input type="checkbox"/> alfuzosin <input type="checkbox"/> finasteride <input type="checkbox"/> terazosin <input type="checkbox"/> doxazosin <input type="checkbox"/> tamsulosin						<input type="checkbox"/> Yes <i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i> <input type="checkbox"/> No		
2. Does the Recipient have a contraindication or intolerance to any of the preferred BPH agents listed in question (1)?						<input type="checkbox"/> Yes <i>Submit medical record documentation of contraindications/intolerances</i> <input type="checkbox"/> No		
<u>SECTION B: CIALIS REQUESTS ONLY</u>								
1. Does the Recipient have a diagnosis of benign prostatic hyperplasia (BPH)?						<input type="checkbox"/> Yes – <i>submit medical record documentation supporting Recipient's diagnosis of BPH</i> <input type="checkbox"/> No		

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

Prescriber Signature:	Date:
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