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

ANXIOLYTICS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Anxiolytics** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Additional info ☐Renewal request PA# _____	# pgs 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:	☐alprazolam ODT ☐alprazolam ER tablet ☐alprazolam intensol ☐Ativan tablet*	☐clorazepate tablet ☐diazepam intensol ☐diazepam injection syringe ☐meprobamate tablet	☐oxazepam capsule ☐Tranxene T-tab* ☐Xanax tablet* ☐Xanax XR tablet*

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Did the prescriber or prescriber's delegate search the PDMP to review the Recipient's controlled substance prescription history before issuing this prescription for the requested agent?	☐Yes ☐No *Submit documentation.*
2. Does the Recipient have a history of trial and failure of the preferred Anxiolytics? *Check all that apply.* ☐alprazolam tablet ☐diazepam injection vial ☐lorazepam intensol ☐buspirone tablet ☐diazepam oral solution ☐lorazepam tablet ☐chlordiazepoxide capsule ☐diazepam tablet	☐Yes – *submit all supporting documentation of preferred agents tried and treatment outcomes.* ☐No
3. Does the recipient have any contraindications or intolerances of the preferred Anxiolytics listed in question (2)?	☐Yes – *submit all supporting documentation of contraindications or intolerances.* ☐No
4. Does the request exceed the quantity limit/daily dose limit? (Refer to Quantity Limits/Daily Dose Limits at http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.)	☐Yes – *submit documentation supporting the prescribed quantity/dosing.* ☐No
5. ***For non-preferred agents marked with a ****, is this a brand medically necessary request?	☐Yes – *submit documentation supporting why generic cannot be used.* ☐No

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

Prescriber Signature:	**Date**: