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

HISTAMINE-2 RECEPTOR BLOCKERS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.).

To review the prior authorization guidelines for Histamine-2 Receptor Blockers, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Histamine-2 Receptor Blockers** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	☐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:

☐cimetidine tablet (Rx or OTC)
☐cimetidine solution
☐famotidine suspension
☐famotidine/calcium carbonate/magnesium hydroxide chewable
☐nizatidine capsule
☐nizatidine solution
☐Pepcid suspension
☐Pepcid tablet
☐ranitidine capsule
☐ranitidine injection
☐Zantac tablet (Rx or OTC)
☐Zantac injection

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code *(required)*:	

1. Has the Recipient tried and failed any of the preferred Histamine-2 Receptor Blockers? ☐famotidine tablet (Rx or OTC) or injection ☐ranitidine tablet (Rx or OTC) or syrup	☐Yes ☐No	*Submit medical record documentation of Recipient's medication regimen and response to treatment*
2. Does the Recipient have a contraindication or intolerance to any of the preferred Histamine-2 Receptor Blockers listed in question (1)?	☐Yes ☐No	*Submit medical record documentation of contraindications/intolerances*

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

Prescriber Signature:	**Date**: