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**

# GLUCOCORTICOIDS, INHALED PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Glucocorticoids, Inhaled** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

| PRIOR AUTHORIZATION INFORMATION | | PRESCRIBER INFORMATION | |
|---|---|---|---|
| ☐New request ☐Renewal request | total # of pgs: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | State license #: | |
| LTC facility contact/phone: | | NPI: | MA Provider ID#: |
| **BENEFICIARY INFORMATION** | | Street address: | |
| Beneficiary name: | | Suite #: | City/state/zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | | |
|---|---|---|---|
| **Non-preferred medication requested:** | ☐AirDuo RespiClick | ☐Asmanex HFA | ☐fluticasone/salmeterol |
| | ☐Alvesco HFA | ☐Asmanex Twisthaler | ☐Pulmicort Respule |
| | ☐ArmonAir RespiClick | ☐Breo Ellipta | ☐QVAR RediHaler |
| | ☐Arnuity Ellipta | ☐budesonide respule | ☐_____ |

| | | | |
|---|---|---|---|
| Strength: | Directions: | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | | Diagnosis code *(required)*: | |

| | | |
|---|---|---|
| 1. Did the beneficiary try and fail the preferred Inhaled Glucocorticoids? *Check all that apply.*<br>☐Advair Diskus or HFA ☐Flovent Diskus or HFA ☐Symbicort HFA<br>☐Dulera HFA ☐Pulmicort Flexhaler | ☐Yes<br>☐No | *Submit medical record documentation of beneficiary's medication regimen and response to treatment.* |
| 2. Does the beneficiary have a contraindication or intolerance to any of the preferred Inhaled Glucocorticoids listed in question (1)? | ☐Yes<br>☐No | *Submit medical record documentation of contraindications/intolerances.* |

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

| | |
|---|---|
| **Prescriber Signature:** | **Date**: |