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

PRENATAL VITAMINS 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 Prenatal Vitamins, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Prenatal Vitamins** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _______	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

- ☐Dothelle DHA softgel
- ☐Elite-OB caplet
- ☐Focalgin 90 DHA Combo Pack
- ☐Folivane-OB capsule
- ☐OB Complete caplet
- ☐OB Complete + DHA softgel
- ☐OB Complete Gold softgel
- ☐OB Complete One softgel
- ☐OB Complete Petite softgel
- ☐OB Complete Premier tablet
- ☐Provida DHA capsule
- ☐Provida OB capsule
- ☐Taron-C DHA capsule
- ☐Taron-Prex Prenatal DHA capsule
- ☐Ultimatecare One capsule
- ☐Virt-Nate DHA softgel
- ☐Virt-Select capsule
- ☐VP-PNV-DHA capsule
- ☐Zatean-PN DHA capsule
- ☐Zatean-PN Plus softgel
- ☐____________________

Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

1. Has the beneficiary tried and failed any of the preferred Prenatal Vitamins? *Check all that apply.*
   - ☐Complete Natal DHA combo pack
   - ☐Completenate chewable
   - ☐Niva-Plus tablet
   - ☐O-Cal FA tablet
   - ☐PNV 29-1 mg tablet
   - ☐Preplus Ca-Fe-FA tablet
   - ☐Trinatal Rx 1 tablet
   - ☐Triveen-Duo DHA combo pack
   - ☐Virt-Advance tablet
   - ☐Virt-Nate tablet
   - ☐Virt-PN tablet
   - ☐Virt-PN DHA Softgel
   - ☐Virtprex capsule
   - ☐Vol-Nate tablet
   - ☐Vol-Plus tablet

   ☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.*
   ☐No

2. Does the beneficiary have any contraindications or intolerances to the preferred agents listed in question (1)?

   ☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances and contraindications.*
   ☐No

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

Prescriber Signature:	**Date**:

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