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

QUANTITY LIMITS/DAILY DOSE LIMITS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines regarding Quantity Limits and Daily Dose Limits, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Quantity Limits/Daily Dose Limits** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- The list of Quantity Limits and Daily Dose Limits can be found on the Pharmacy Service's web site at http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request 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

Name of medication requested:	Strength:	
Directions/frequency:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (required):	

If the requested medication is a narcotic analgesic, complete Section B. For all other medications, complete Section A.

Section A: Non-narcotic request

1. What is the medical reason the Recipient requires the requested medication at a dose that exceeds the quantity limits/daily dose limits? *Check all that apply.* ☐the Recipient requires a dose that includes ½ tablets to achieve the total daily dose ☐the dose of the requested medication is being titrated or tapered ☐the Recipient has a history of intolerance to taking the medication at the FDA-approved frequency of administration	*Submit documentation of* • *requested medication regimen* • *past and current doses* • *medical rationale for exceeding the quantity limit, such as treatment results of other medications or dosages, lab results, physical exam, imaging, etc.*
2. Is the requested dose and frequency consistent with medically-accepted prescribing practices and standards of care, including support from peer-reviewed literature or national treatment guidelines?	☐Yes ☐No *Submit medical literature supporting dose & frequency.*

Section B: Narcotic analgesics request

1. Which of the following apply to the Recipient? *Check all that apply*. *Submit medical record documentation supporting each option checked*.

☐history of moderate to severe pain
☐inadequate pain control at dose/frequency within quantity limits
☐cancer diagnosis
☐history of contraindication or intolerance to other narcotic analgesics
☐drug/dose prescribed by, or in consultation with, a specialist
☐*for short-acting narcotic requests*, attempts to start or increase dose of a long-acting narcotic analgesic
☐*for long-acting narcotic requests*, inadequate pain control with or contraindication/intolerance of other long-acting narcotic analgesics

2. List all other pain medications, including doses and frequency of administration, that have been tried by the Recipient. *Submit documentation of all agents tried and treatment outcomes for each medication.*

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

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

Prescriber Signature:	**Date**: