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

ANTIPSORIATICS, ORAL PRIOR AUTHORIZATION FORM

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

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# 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:	☐methoxsalen rapid capsule ☐Oxsoralen-Ultra soft gelatin capsule ☐Soriatane capsule		
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antipsoriatic, Oral agent, **acitretin capsule**?	☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.* ☐No

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

Prescriber Signature:	**Date**:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.