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

EPINEPHRINE, SELF-INJECTED PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Self-Injected Epinephrine products, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Epinephrine, Self-Injected** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION 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:	☐epinephrine 0.15 mg auto-injector *(all mfrs except Mylan Specialty)* ☐epinephrine 0.3 mg auto-injector *(all mfrs except Mylan Specialty)* ☐EpiPen Jr. 0.15 mg auto-injector ☐EpiPen 0.3 mg auto-injector		
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
1. Has the Beneficiary tried and failed the preferred Self-Injected Epinephrine product, **epinephrine 0.3 mg or 0.15 mg auto-injector *(manufactured by Mylan Specialty)***?		☐Yes – *Submit all supporting documentation of drug regimen tried and treatment outcomes.* ☐No	
2. Does the Beneficiary have any contraindications or intolerances to the preferred Self-Injected Epinephrine product listed in question (1)?		☐Yes – *Submit all supporting documentation of medication name 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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