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

PANCREATIC ENZYMES PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Pancreatic Enzymes** 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	# 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:	☐Pancreaze DR capsule ☐Pertzye DR capsule		☐Viokace tablet ☐ ______	
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 Pancreatic Enzymes? *Check all that apply.* ☐Creon DR capsule ☐Zenpep DR capsule			☐Yes – *Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.* ☐No	
2. Has the beneficiary been taking the requested non-preferred medication within the past 90 days?			☐Yes - *Submit documentation of drug regimen and clinical response.* ☐No	

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

Prescriber Signature:	**Date**:

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