Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

pennsylvania DEPARTMENT OF HUMAN SERVICES

ULCERATIVE COLITIS AGENTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Ulcerative Colitis** and **Quantity Limits/Daily Dose Limits** 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	total # of pgs: _________	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:

☐Asacol HD tablet	☐Giazo tablet	☐Rowasa enema kit
☐Azulfidine tablet	☐Lialda DR tablet	☐Sfrowasa rectal enema
☐Azulfidine EN-tab	☐mesalamine DR tablet	☐Uceris ER tablet
☐Colazal capsule	☐mesalamine rectal enema	☐Uceris rectal foam
☐Dipentum capsule	☐mesalamine rectal enema kit	☐_______________________

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 Ulcerative Colitis Agents? *Check all that apply.* ☐Apriso ER capsule ☐Pentasa ER capsule ☐balsalazide capsule ☐sulfasalazine tablet ☐Canasa rectal suppository ☐sulfasalazine DR tablet ☐Delzicol DR capsule	☐Yes – *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.* ☐No
2. Has the beneficiary been taking the requested non-preferred medication within the past 90 days?	☐Yes ☐No *Submit documentation of drug regimen and clinical response.*
3. ***For Uceris ER (budesonide ER) tablet only***, does the beneficiary have a history of trial and failure, contraindication, or intolerance of other oral corticosteroids (e.g., prednisone, prednisolone, etc.) for the treatment of ulcerative colitis?	☐Yes – *Submit documentation of medication regimens tried and treatment responses, contraindications, and/or intolerances.* ☐No

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

Prescriber Signature:	**Date**:

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Form effective 1/28/19