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

HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hypoglycemics, Thiazolidinediones (TZDs)** and **Quantity Limits/Daily Dose Limits** are available on the 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

Preferred medication requested (clinical prior authorization required):	☐pioglitazone tablet		
Non-preferred medication requested:	☐Actoplus Met tablet ☐Actoplus Met XR tablet ☐Avandia tablet	☐Duetact tablet ☐pioglitazone/glimepiride tablet	☐pioglitazone/metformin tablet ☐______________
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the beneficiary have a diagnosis of type 2 diabetes?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of maximum tolerated doses of **metformin**?	☐Yes ☐No *Submit documentation showing trial and failure of, or contraindication or intolerance to, metformin (including result of a recent HbA1c).*
3. ***Requests for NON-PREFERRED agents only:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred thiazolidinedione, ***pioglitazone***?	☐Yes ☐No *Submit all supporting documentation of preferred agent tried and treatment outcomes, including contraindications or intolerances.*

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.