

**QUANTITY/DAILY DOSE/DURATION LIMITS PRIOR AUTHORIZATION FORM**

Prior authorization guidelines for **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

A list of all quantity limits, daily dose limits, and duration limits is available at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:			Street address:	
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

**CLINICAL INFORMATION**

Product requested:	Strength:	
Directions/frequency:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):	DX code (required):	

What is the medical reason the beneficiary requires the requested medication at a dose that exceeds the quantity limits/daily dose limits? *Check all that apply and SUBMIT DOCUMENTATION from the medical record and/or medical literature supporting the rationale for the requested quantity/dose/duration.*

- the beneficiary requires a dose that includes ½ tablets to achieve the total daily dose
- the dose of the requested medication is being titrated or tapered
- the beneficiary has a history of intolerance to taking the medication at the FDA-approved frequency of administration
- the quantity/daily dose/duration are supported by current medical compendia and/or peer-reviewed medical literature

Which of the following apply to the beneficiary? Check all that apply and **SUBMIT MEDICAL RECORD DOCUMENTATION** supporting each item.

**OPIOID ANALGESICS:**

- being treated for moderate-to-severe pain
- inadequate pain control at dose/frequency within quantity limits
- cancer diagnosis
- history of contraindication or intolerance to other opioid analgesics
- drug/dose prescribed by or in consultation with a specialist
- for short-acting narcotic requests, attempts to start or increase dose of a long-acting narcotic analgesic
- for long-acting narcotic requests, inadequate pain control with or contraindication/intolerance of other long-acting narcotic analgesics

**TRIPTANS:**

- Has a diagnosis of chronic, severe migraine in accordance with the International Classification of Headache Disorders criteria
- Has a history of trial and failure of or contraindication or intolerance to other medications for the prevention of migraine
  - anticonvulsants
  - calcium channel blockers
  - tricyclic antidepressants
  - beta blockers
  - SSRIs
  - other: \_\_\_\_\_

**INJECTABLE ANTICOAGULANTS:**

- Has a medical condition that requires more than 10 days of therapy with an injectable anticoagulant
- Cannot use an oral anticoagulant for the medical condition

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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