**QUANTITY/DAILY DOSE/DURATION LIMITS PRIOR AUTHORIZATION FORM** (form effective 01/05/2021)

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](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](https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx).

<table>
<thead>
<tr>
<th>New request</th>
<th>Renewal request</th>
<th># of pages:</th>
<th>Prescriber name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of office contact:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Contact’s phone number:</td>
<td></td>
<td>NPI:</td>
<td>State license #:</td>
</tr>
<tr>
<td>LTC facility contact/phone:</td>
<td></td>
<td>Street address:</td>
<td></td>
</tr>
<tr>
<td>Beneficiary name:</td>
<td></td>
<td>Suite #:</td>
<td>City/state/zip:</td>
</tr>
<tr>
<td>Beneficiary ID#:</td>
<td></td>
<td>DOB:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

**CLINICAL INFORMATION**

<table>
<thead>
<tr>
<th>Product requested:</th>
<th>Strength:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directions/frequency:</td>
<td>Quantity:</td>
</tr>
<tr>
<td>Diagnosis (submit documentation):</td>
<td>Dx code (required):</td>
</tr>
</tbody>
</table>

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
- Higher strength(s) of the medication are unavailable due a supply issue (e.g., manufacturer backorder or discontinuation)

Please complete the sections below that apply to the beneficiary and this request. Check all that apply and **SUBMIT MEDICAL RECORD DOCUMENTATION** supporting each item.

**OPIOID ANALGESICS:**

- Is being treated for moderate pain
- Is being treated for severe pain
- Had inadequate pain control at dose/frequency within quantity limits
- The drug/dose is prescribed by or in consultation with a specialist
- For short-acting opioids:
  - Cannot use a long-acting opioid analgesic
  - Cannot increase the dose of a currently prescribed long-acting opioid analgesic
  - A long-acting opioid analgesic is not appropriate for the beneficiary
  - Has inadequate pain control with or contraindication/intolerance of other short-acting opioid analgesics
<table>
<thead>
<tr>
<th>For long-acting opioids:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Has inadequate pain control with or contraindication/intolerance of other long-acting opioid analgesics</td>
</tr>
<tr>
<td>☐ Dose is being appropriately titrated or converted from other opioid analgesics</td>
</tr>
</tbody>
</table>

**MIGRAINE ACUTE TREATMENT AGENTS:**

- ☐ The drug/dose is prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties
- ☐ If being used for the acute treatment of migraine:
  - ☐ Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)
  - ☐ Will be using the requested medication with at least one medication for migraine prevention – specify:
    - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
    - ☐ antidepressant (e.g., SNRI, TCA)
    - ☐ other: _________________________________________
  - ☐ Tried and failed preventive migraine medications – specify:
    - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
    - ☐ antidepressant (e.g., SNRI, TCA)
    - ☐ other: _________________________________________
  - ☐ Has an intolerance or a contraindication to preventive migraine medications – specify:
    - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
    - ☐ antidepressant (e.g., SNRI, TCA)
    - ☐ 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**

<table>
<thead>
<tr>
<th>Prescriber Signature:</th>
<th>Date:</th>
</tr>
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