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

BENZODIAZEPINES PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines and 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.

☐New request ☐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:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Benzodiazepine requested:	Strength:	Dosage form (capsule, tablet, etc.):	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
If the requested benzodiazepine is non-preferred, did the beneficiary try and fail the preferred benzodiazepines approved or medically accepted for the treatment of their condition? *Refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred drugs.*		☐Yes – *Submit documentation.* ☐No	

Benzodiazepines (preferred and non-preferred) require prior authorization in the scenarios listed below. Check all options that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each.

☐The beneficiary is **under 21 years of age** and:
- ☐Has a diagnosis of *(check all that apply)*:
  - ☐seizure disorder
  - ☐chemo-induced nausea/vomiting
  - ☐cerebral palsy
  - ☐spastic disorder
  - ☐dystonia
  - ☐catatonia
- ☐Has symptoms of severe acute anxiety AND:
  - ☐Has chart documented evidence of a comprehensive evaluation
  - ☐Is prescribed the benzodiazepine by or in consultation with a psychiatrist
- ☐Is receiving palliative care

☐The beneficiary is **taking 2 or more different benzodiazepines concurrently (therapeutic duplication)** AND:
- ☐Concomitant use of the benzodiazepines is supported by national treatment guidelines or medical literature
- ☐Is being titrated to or tapered from one benzodiazepine to the other

☐The beneficiary **filled 2 or more prescriptions for any benzodiazepine** in the past 30 days AND:
- ☐The prescriptions are for the same benzodiazepine, strength, and directions for use

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- ☐ Each prescription was filled for <30 days' supply
- ☐ Other reason for filling >1 benzodiazepine prescription in the past 30 days – specify: _____
- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers AND:
  - ☐ All prescribers are aware of the other benzodiazepine prescriptions
- ☐ The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed medical literature or national treatment guidelines

☐ The beneficiary has a concurrent prescription for another controlled substance and:

- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers
  - ☐ All prescribers are aware of the other prescriptions
- ☐ Has an acute need for the requested benzodiazepine – specify: _____

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

Prescriber Signature:	Date: