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

VECAMYL (mecamylamine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Vecamyl (mecamylamine)** 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:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Vecamyl tablet	Strength:	Quantity:	Refills:
Directions:			

Diagnosis:	Dx code (*required*):
Does the beneficiary have any of the following contraindications to Vecamyl? *Check all that apply.* ☐mild, moderate, or labile hypertension ☐heart disease (CAD or coronary insufficiency) ☐recent myocardial infarction (MI) ☐renal impairment ☐glaucoma ☐pyloric stenosis ☐currently taking antibiotics or sulfonamides	☐Yes ☐No *Submit documentation, including lab results, current medication list, etc.*

INITIAL requests

Is Vecamyl being prescribed by or in consultation with a hypertension specialist?	☐Yes ☐No *Submit documentation of consultation with specialist if applicable.*
Does the beneficiary have a diagnosis of severe essential (primary) hypertension or uncomplicated malignant hypertension?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of Vecamyl for the beneficiary's diagnosis.*
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the following first- and second-line antihypertensive drug classes at maximal tolerated doses? *Check all that apply.* ☐ACE inhibitor (e.g., lisinopril, enalapril, ramipril, captopril) ☐angiotensin receptor blocker (ARB) (e.g., losartan, valsartan, irbesartan) ☐calcium channel blocker (CCB) (e.g., amlodipine, diltiazem, nifedipine) ☐thiazide diuretic (e.g., hydrochlorothiazide, chlorthalidone, indapamide)	☐Yes ☐No *Submit documentation of all medications tried and treatment outcomes or contraindications/intolerances.*

RENEWAL requests

Has the beneficiary experienced an improvement in blood pressure since starting Vecamyl?	☐Yes ☐No *Submit documentation of beneficiary's blood pressure response.*

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

Prescriber Signature:	Date:

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