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

MACULAR DEGENERATION AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Macular Degeneration Agents** 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	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (syringe, vial, etc.):
Directions (dose, eye[s] to be treated, frequency, etc.):		Requested duration:
Diagnosis:		Dx code *(required)*:

INITIAL requests

Has the beneficiary tried and failed or have a contraindication or an intolerance to intravitreal bevacizumab?	☐Yes – *Submit all supporting documentation of bevacizumab regimen and treatment outcome.* ☐No ☐Not clinically appropriate
For a non-preferred medication: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit documentation.* ☐No ☐Not applicable to diagnosis

RENEWAL requests

List previous doses of the requested medication:

Right eye: _____

Left eye: _____

Has the beneficiary experienced a positive clinical response to previously administered doses of the requested medication?	☐Yes ☐No *Submit medical record documentation of beneficiary's response to treatment.*

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

Prescriber Signature:	Date: