Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CLINICAL PRIOR AUTHORIZATION FORM for NON-PDL DRUGS *(form effective 7/6/2026)*

Prior authorization guidelines **Clinical Prior Authorization for Non-PDL Drugs** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

Beneficiary name:	Beneficiary ID#:	Beneficiary DOB:
Prescriber name:		Prescriber NPI:
Prescriber address (street/city/state/zip):		
Prescriber specialty:	Prescriber phone:	Prescriber fax:
Office contact name:	Office contact phone:	Office contact fax:
Billing provider name:		Billing provider NPI:
Billing provider address:		

CLINICAL INFORMATION

Drug requested:			Dosage form:
Strength:	Quantity:	Duration:	Beneficiary's weight:
Dose/directions:		Place of service:	
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

- ☐ The requested drug is being used for the treatment of a diagnosis that is indicated in the FDA-approved package labeling OR a medically accepted indication
- ☐ The beneficiary is of an appropriate age to receive the requested drug according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- ☐ The prescribed dose and duration of therapy are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- ☐ The requested drug is prescribed by or in consultation with an appropriate specialist
- ☐ The beneficiary does not have a contraindication to the requested drug
- ☐ The beneficiary has baseline lab results as recommended in the FDA-approved package labeling

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☐ The beneficiary tried and failed or has a contraindication or an intolerance to first-line therapy(ies), if applicable, according to consensus treatment guidelines

☐ The beneficiary has not failed a previous course or trial of the requested drug

☐ The beneficiary is not currently enrolled in a clinical trial for the requested drug

RENEWAL requests

☐ The beneficiary has documentation of a positive clinical response to the requested drug

☐ The prescribed dose and duration of therapy are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ The requested drug is prescribed by or in consultation with an appropriate specialist

☐ The beneficiary does not have a contraindication to the requested drug

☐ The beneficiary has results of recent lab monitoring as recommended in the FDA-approved package labeling

☐ If applicable to the requested drug, the beneficiary is continuing treatment with the requested drug based on recent lab results as recommended in the FDA-approved package labeling

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

Prescriber Signature:	**Date**:

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