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

QUANTITY / DAILY DOSE LIMITS PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

- Prior authorization guidelines for **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/pharmacy-services/specialty-pharmacy-program.
- A **list of all quantity limits, daily dose limits, and duration limits** is available at https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.

☐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

Product requested:	Strength:	
Directions/frequency:	Quantity per fill:	Duration:
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.

1. For ALL requests: What is the medical reason the beneficiary requires the requested drug at a dose that exceeds the quantity limits/daily dose limits?

☐The requested dose requires partial units (eg, half-tablets) that cannot be obtained using a single commercially available strength of the drug

☐Requires a dose that includes multiple units that cannot be consolidated to use a single higher commercially available strength of the requested drug

☐The dose is being titrated by the prescriber (3-month limit) (does not apply if the drug is also available in a titration pack from the manufacturer that can be used for the requested titration dosing and is listed as preferred on the Statewide Preferred Drug List [PDL]*)

**Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs on the Statewide PDL.*

☐Has a medical reason why fewer daily doses cannot be utilized (e.g., intolerance to higher doses given less frequently, inadequate response to fewer daily doses)

☐Utilization of lower doses of the requested drug was ineffective in managing the beneficiary's condition

☐The prescribed daily dose is consistent with medically accepted prescribing practices and standards of care (e.g., peer-reviewed medical literature or national treatment guidelines that corroborate use of the quantity of drug prescribed

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

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2. For an OPIOID ANALGESIC (e.g., codeine and derivatives, morphine and derivatives):

☐ Pain is inadequately controlled with a dose and frequency at the established quantity limits

☐ **For a SHORT-ACTING opioid**:
- ☐ Has a history of inadequate pain control with or a contraindication or an intolerance to other short-acting opioid analgesics
- ☐ Initiation of a long-acting opioid analgesic is not appropriate for the beneficiary
- ☐ Dose adjustment of a concomitant long-acting opioid analgesic is not appropriate for the beneficiary

☐ **For a LONG-ACTING opioid**:
- ☐ Has a history of inadequate pain control with or a contraindication or an intolerance to other long-acting opioid analgesics
- ☐ Dose is being appropriately titrated or converted from other opioid analgesics

3. For a MIGRAINE ACUTE TREATMENT AGENT (e.g., triptans, ditans, gepants, ergot alkaloids):

☐ 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 drugs (e.g., opioids, triptans, butalbital, etc.)
- ☐ Will be using the requested drug with at least one drug for migraine prevention – specify:
  - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
  - ☐ antidepressant (e.g., SNRI, TCA)
  - ☐ other: _____
  - ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
  - ☐ CRGP monoclonal antibody (e.g., Aimovig, Emgality)
- ☐ Tried and failed preventive migraine drugs – specify:
  - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
  - ☐ antidepressant (e.g., SNRI, TCA)
  - ☐ other: _____
  - ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
  - ☐ CRGP monoclonal antibody (e.g., Aimovig, Emgality)
- ☐ Has an intolerance or a contraindication to preventive migraine drugs – specify:
  - ☐ anticonvulsant (e.g., topiramate, valproate derivative)
  - ☐ antidepressant (e.g., SNRI, TCA)
  - ☐ other: _____
  - ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
  - ☐ CRGP monoclonal antibody (e.g., Aimovig, Emgality)

4. For an INJECTABLE ANTICOAGULANT (e.g., enoxaparin, dalteparin):

☐ 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

Prescriber Signature:	**Date**:

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