



GLUCOCORTICOIDS, ORAL PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

Prior authorization guidelines for **Glucocorticoids, Oral** 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>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total 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

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	DX code (<i>required</i>):	

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

<p>1. For a NON-PREFERRED Glucocorticoid, Oral:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred Glucocorticoids, Oral that are approved or medically accepted for the beneficiary's diagnosis (<i>Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.</i>)</p>
<p>2. For treatment of EOSINOPHILIC ESOPHAGITIS (EOE):</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to inhaled fluticasone propionate</p>
<p>3. For treatment of PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN):</p> <p><input type="checkbox"/> Has a diagnosis of IgAN that is confirmed by a kidney biopsy</p> <p><input type="checkbox"/> Is prescribed the requested drug by or in consultation with a nephrologist</p> <p><input type="checkbox"/> Has 3 or more of the following features indicating the beneficiary is at very high risk for progressive disease or already has progressive disease despite at least 3 to 6 months of maximally tolerated doses of an ACE inhibitor or ARB based on current consensus guidelines:</p> <p><input type="checkbox"/> Persistent proteinuria ≥ 1 g/day on at least 2 separate tests</p> <p><input type="checkbox"/> Persistent moderate microscopic hematuria/hemoglobinuria (arbitrarily defined as 1+ or greater on urine dipstick or >10 RBCs/hpf on at least two separate tests, in the absence of another possible cause)</p>



- Progressive decline in kidney function (eg, documented or inferred by an eGFR 3 mL/min/1.73 m² per year) considered to be due to active IgAN
- Evidence of one or more active lesions on recent kidney biopsy (eg, Oxford classification M1, E1, or C1 or C2 scores [particularly crescents involving >10 percent of glomeruli]) or an S1 lesion with podocyte hypertrophy
- Has an eGFR \geq 35 mL/min/1.73 m²

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

Prescriber Signature:

Date:

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