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

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Glucocorticoids, Oral** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

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

1. For a NON-PREFERRED Glucocorticoid, Oral:

☐Tried and failed or has a contraindication or an intolerance to the preferred Glucocorticoids, Oral that are approved or medically accepted for the member's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For treatment of EOSINOPHILIC ESOPHAGITIS (EOE):

☐Tried and failed or has a contraindication or an intolerance to inhaled fluticasone propionate

3. For treatment of PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN):

☐Has a diagnosis of IgAN that is confirmed by a kidney biopsy
☐Is prescribed the requested drug by or in consultation with a nephrologist
☐Has 3 or more of the following features indicating the member 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:
☐Persistent proteinuria ≥1 g/day on at least 2 separate tests

- ☐ 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)
- ☐ 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 ≥35 mL/min/1.73 m2

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)