

All requests for Duplicate Therapy require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Duplicate Therapy Prior Authorization Criteria:**

All requests for medications within the classes listed below will require a Prior Authorization when the member is prescribed more than one medication in the same therapeutic class within a 30 day period (therapeutic duplication). Requests for therapeutic duplication will be reviewed for medical necessity and appropriateness.

The Pharmacy Department will follow the procedures outlined in CP-206-MD-DE after receiving a request for a Prior Authorization for requests for use of more than one medication in the following therapeutic classes:

- Long-Acting Narcotic Analgesics
- Non-benzodiazepine hypnotics (i.e. zolpidem, eszopiclone, etc.)
- Oral Anticoagulants
- Skeletal Muscle Relaxants
- Benzodiazepines
- Hereditary Angioedema Acute Attack Agents
- Hereditary Angioedema Prophylaxis Agents
- Gabapentinoids

In evaluating a request for Prior Authorization of a prescription that duplicates therapy, the determination of whether the requested prescription is medically necessary will take into account the following:

1. The member's diagnosis;
2. Whether the member is being titrated to, or tapered from a drug in the same class.
3. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested.

**THERAPEUTIC DUPLICATION  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services.

**FAX:** (855) 476-4158

If needed, you may call to speak to a Pharmacy Services Representative.

**PHONE:** (844) 325-6251 Monday through Friday 8:00am to 7:00pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:	
Member ID:	Member weight:	Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?  Yes  No

**Billing Information**

This medication will be billed:  at a pharmacy **OR**  
 medically (if medically please provide a

JCODE: \_\_\_\_\_

Place of Service:  Hospital  Provider's office  Member's home  Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

What is the member's diagnosis: \_\_\_\_\_  
 Is the member being tapered off a medication?  Yes  No Name of medication being stopped: \_\_\_\_\_ Name of medication being started: \_\_\_\_\_

Please provide any other necessary information for why the member requires treatment with more than one medication from the same therapeutic class (i.e. chart notes, lab results, etc.):

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**CURRENT or PREVIOUS THERAPY**

**HIGHMARK**    
**HEALTH OPTIONS**

Updated: 08/2022  
DMMA Approved: 08/2022

<b>Medication Name</b>	<b>Strength/ Frequency</b>	<b>Dates of Therapy</b>	<b>Status (Discontinued &amp; Why/Current)</b>