Alabama Medicaid Pharmacy
Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Kepro

P.O. Box 3570
Auburn, AL 36831-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Practitioner Signature Date

CLINICAL INFORMATION

Drug requested* _____ Strength _____

J Code _____ Qty. _____ Days supply _____ PA Refills: ○0 ○1 ○2 ○3 ○4 ○5 Other _____
If applicable

Diagnosis or ICD-10 Code _____ Diagnosis or ICD-10 Code _____

☐ Initial Request ☐ Renewal ☐ Maintenance Therapy ☐ Acute Therapy

Medical justification _____

☐ **Additional medical justification attached.** **Medications received through coupons and samples are not acceptable as justification.**

*If the drug being requested is a brand name drug with an exact generic equivalent available, the FDA MedWatch Form 3500 must be submitted to Kepro in addition to the PA Request Form.

DRUG SPECIFIC INFORMATION

☐ ADD/ADHD Agents ☐ Alzheimer's Agent ☐ Androgens ☐ Antidepressants ☐ Antidiabetic Agent ☐ Antiemetic Agents ☐ Antigout
☐ Antihistamine ☐ Antihyperlipidemics ☐ Antihypertensives ☐ Antiinfective ☐ Antipsychotic Agents ☐ Anxiolytics, Sedatives & Hypnotics
☐ Cardiac Agents ☐ CGRP/Migraine ☐ EENT-Antiallergics ☐ EENT-Antibacterials ☐ EENT-Vasoconstrictors ☐ Estrogens
☐ Genitourinary Agents ☐ H2 Antagonist ☐ Hereditary Angioedema Agents ☐ Intranasal Corticosteroids ☐ Multiple Sclerosis
☐ Narcotic Analgesics ☐ NSAID ☐ Oral Anticoagulants ☐ Platelet Aggregation Inhibitors ☐ PPI ☐ Prenatal Vitamins
☐ Respiratory Agents ☐ Skeletal Muscle Relaxants ☐ Skin & Mucous Membrane Agent ☐ Triptans ☐ Wakefulness Promoting Agents
☐ Other

List previous drug usage and length of treatment as defined in instructions for drug class requested.

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____
Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

DISPENSING PHARMACY INFORMATION
May Be Completed by Pharmacy

Dispensing pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

NOTE: See instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.alabama.gov.

 Patient Medicaid #_____

☐ **Antipsychotic Agents** The request is for: ☐ Monotherapy or ☐ Polytherapy

For children < 6 years of age, have monitoring protocols (see Attachment C on the Alabama Medicaid website) been followed? ☐ Yes ☐ No

For **polytherapy** and/or **off-label use**, please provide medical justification to support the use of the drug being requested.

Medical justification may include peer reviewed literature, medical record documentation, chart notes with specific symptoms that the support the diagnosis, etc._____

_____

_____

☐ **Calcitonin Gene-Related Peptide (CGRP)/Migraine Agents**

Indicate the number of migraines per month_____

☐ **Hereditary Angioedema Agents** ☐ Acute Treatment ☐ Prophylaxis

Has the diagnosis been confirmed by an ENT, allergist or immunologist? ☐ Yes ☐ No

Name of Specialist:_____

Failure or inadequate response to the following alternate therapies:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Contraindication of alternate therapies: _____

For prophylaxis, include documentation of frequency and severity of past events.

☐ **Phosphodiesterase Inhibitors**

Failure or inadequate response to the following alternate therapies:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Contraindication of alternate therapies:_____

☐ Documentation of vasoreactivity test attached ☐ Consultation with specialist attached

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☐ **Specialized Nutritionals** Height_____inches Current weight_____kg.

☐ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition

☐ If ≥ 21 years of age, record supports 100% of need is met by specialized nutrition

Method of administration_____Duration_____# of refills_____

☐ **Sustained Release Oral Opioid Agonist**

Proposed duration of therapy_____ Is medicine for PRN use? ☐ Yes ☐ No

Type of pain ☐ Acute ☐ Chronic Severity of pain: ☐ Mild ☐ Moderate ☐ Severe

Is there a history of substance abuse or addiction? ☐ Yes ☐ No

If yes, is treatment plan attached? ☐ Yes ☐ No

Indicate prior and/or current analgesic therapy and alternative management choices

Drug/therapy _____ Reason for d/c _____

Drug/therapy _____ Reason for d/c _____

☐ **Tzield®**

Is the patient ≥ 8 years of age and has a diagnosis of Stage 2 type 1 diabetes confirmed by documentation of at least 2 positive pancreatic islet cell autoantibodies AND dysglycemia without overt hyperglycemia using an oral glucose tolerance test (or alternative method if appropriate and oral glucose tolerance test is not available)? ☐ Yes ☐ No

Indicate at least two pancreatic islet cell autoantibodies identified_____

_____

Has a complete blood count and liver enzyme tests been obtained and evaluated? ☐ Yes ☐ No

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☐ **Xenical®**

☐ If initial request Weight_____kg. Height_____inches BMI_____kg/m^2

☐ If renewal request Previous weight_____kg. Current weight_____kg.

Documentation MD supervised exercise/diet regimen ≥ 6 mo.? ☐ Yes ☐ No Planned adjunctive therapy? ☐ Yes ☐ No

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☐ **Xolair®** Current Weight:___kg (patient's weight must be between 20-150kg)

Is the patient 6 years or older? ☐ Yes ☐ No

Is the request for **chronic idiopathic urticaria**? ☐ Yes ☐ No

Is the request for **moderate to severe asthma** and is treatment recommended by a board certified pulmonologist or allergist after their evaluation (if yes answer questions below)? ☐ Yes ☐ No

Has the patient had a positive skin or blood test reaction to a perennial aeroallergen? ☐ Yes ☐ No

Is the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor or an inhaled corticosteroid and long acting beta agonist or has the patient required 3 or more bursts of oral steroids within the past 12 months? ☐ Yes ☐ No

Are the patient's baseline IgE levels between 30 IU/mL and 700 IU/mL (between 30 IU/ml and 1,300 IU/ml for patients 6 to < 12 years of age)? ☐ Yes ☐ No Level_____Date_____
