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 HID 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 ☐ Antipsychotic Agents ☐ Antiinfective ☐ Anxiolytics, Sedatives & Hypnotics
☐ Cardiac Agents ☐ CGRP/Migraine ☐ EENT-Antiallergics ☐ EENT-Vasoconstrictors ☐ EENT-Antibacterials ☐ 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.

☐ **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_____

☐ **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_____

☐ **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_____

☐ **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 answers 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_____

 Patient Medicaid #_____

☐ **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.

☐ **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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