Kentucky Medicaid Pharmacy Prior Authorization Form

- **For Drug Requests (unless noted below) - Complete ONLY Page 1 of This Form.**
- **For Synagis® or Zyvox® requests - Complete Page 1 AND Page 2 of This Form.**
- **For Buprenorphine Products:**
  - **-For Pain Management Diagnosis – Complete ONLY Page 1 of This Form.**
  - **-For Substance Use Treatment - Please use the Kentucky Medicaid Substance Use Treatment Pharmacy Prior Authorization Form.**

Please fax completed form to the corresponding fax number of the health plan partner your patient is currently enrolled. Additional prior authorization forms can be found by clicking on hyperlinks provided to the right.

Plan:	Phone number:	Fax number:
☐ Fee-For-Service (Magellan)	1 (800) 477-3071	1 (800) 365-8835
☐ Anthem Medicaid	1 (855) 661-2028	1 (855) 875-3627
☐ Aetna Better Health	1 (855) 300-5528	1 (855) 799-2550
☐ Humana CareSource	1 (855) 852-7005	1 (866) 930-0019
☐ Passport Health Plan	1 (844) 380-8831	1 (844) 802-1406
☐ WellCare of Kentucky	1 (877) 389-9457	1 (855) 620-1868

Patient Information:

Member Name:		Date of Birth:
Address: City, State, Zip:		
Sex: ☐ Male ☐ Female	Height:	Weight:
Member ID:	Medication Allergies:	

Prescriber Information:

Prescriber Name:	NPI:
Prescriber Address (including city, state and zip):	
Prescriber's Specialty:	DEA:
Phone:	Fax:

Pharmacy Information:

Pharmacy Name:	NPI:
Pharmacy Address (including city, state and zip):	
Phone:	Fax:

Diagnosis and Medical Information for Requested Medication: ☐ INITIAL Request ☐ REAUTHORIZATION (REFILL) Request with current plan

Diagnosis:		ICD-10 Code:
Medication Requested:		Dosage Form:
Strength:	Quantity:	Days' Supply:
Directions for Use:		Duration of Therapy:

Rationale for Prior Authorization:

Brand Medically Necessary? ☐ Yes ☐ No

If yes, please provide medical justification why the patient cannot be appropriately treated with the generic form of the drug.

Please indicate previous treatment and outcomes below:

Previous Medication	Strength	Quantity	Directions (Sig)	Dates (from and to)	Reason for Discontinuation

☐ Patient recently hospitalized - ***If requesting ATYPICAL ANTIPSYCHOTICS, please provide hospitalization dates and discharge dosages of atypical antipsychotics medications in table above.***

Additional Clinical Information or Medical Rationale for Request:

Requesting Provider: ☐ Prescriber ☐ Pharmacy	**Date of Request:**
*Requestor Name (print):	*Requestor Signature:

*On behalf of the Prescriber or Pharmacy Provider, I certify that the information stated above is true, made to allow Kentucky Medicaid to offer prescription coverage to this member for the medication requested above. I understand the designated health plan will retain this document and any attached materials for the purposes of possible future audit(s).

CONTINUE TO NEXT PAGE ONLY IF REQUESTING SYNAGIS® OR ZYVOX®

When requesting Synagis®, provide the following additional information:

Synagis® approvals may begin therapy November 1 with last date of therapy not to exceed March 31 (end of RSV season)

1. Patient's gestational age at birth: _____ weeks _____days
2. Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)?
   ☐ Yes (go to question 2a) ☐ No (go to question 3)
   a. Did the patient receive oxygen immediately following birth? ☐ Yes (go to question 2b) ☐ No (go to question 3)
   b. Please indicate the % oxygen received: _____ Date received: _____ Duration of treatment: _____
   c. Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:
      ☐ Oxygen Most recent date administered: _____
      ☐ Systemic corticosteroids Most recent date administered: _____
      ☐ Diuretics Most recent date administered: _____
3. Does the patient have a diagnosis of Cystic Fibrosis? ☐ Yes (go to question 3a) ☐ No (go to question 4)
   a. Has the patient been hospitalized for a pulmonary exacerbation? ☐ Yes (Date: _____) ☐ No
   b. Does the patient have clinical evidence of chronic lung disease? ☐ Yes ☐ No
   c. Does the patient have clinical evidence of failure to thrive? ☐ Yes ☐ No
   d. Does the patient have pulmonary abnormalities on chest X-ray or CT that persist when the patient is stable? ☐ Yes ☐ No
   e. What is the patient's weight for length percentile? _____
4. Please indicate if patient has any of the following:
   ☐ Anatomic Pulmonary Abnormality (Specify: _____)
   ☐ Neuromuscular Disorder (Specify: _____)
   ☐ Congenital anomaly that impairs the ability to clear secretions (Specify: _____)
5. Please indicate if patient has any of the following:
   ☐ HIV
   ☐ Cancer, receiving chemotherapy
   ☐ Organ transplant receiving immunosuppressant therapy or hematopoietic stem cell transplant
   ☐ Other medical condition that is severely immunocompromising (Specify: _____)
6. Has this patient received a heart transplant? ☐ Yes (Date: _____) ☐ No
7. Does patient have hemodynamically significant congenital heart disease? ☐ Yes ☐ No
   ☐ Acyanotic heart disease (Specify: _____)
   ☐ Cyanotic heart disease (Specify: _____ Name of Pediatric Cardiologist:_____)
   ☐ Pulmonary Hypertension
   ☐ Other: _____
8. Will this patient's congenital heart disease require cardiac surgery? ☐ Yes ☐ No
9. Please list any medications that may be used:
   ☐ Ace-Inhibitor/ARB Most recent date administered: _____
   ☐ Diuretic Most recent date administered: _____
   ☐ Beta-Blocker Most recent date administered: _____
   ☐ Digoxin Most recent date administered: _____
   ☐ Other cardiovascular medications (Specify:) _____
10. If this is a request for a sixth dose of Synagis® during the RSV season, has the patient had an ECMO or cardiac bypass during the RSV season?
    ☐ Yes (Date: _____) ☐ No
    Note: Synagis is available in 50mg and 100mg vials. Always coordinate dosing appropriately to reduce waste.

When requesting Zyvox®, provide the following additional information:

Pertinent Diagnosis:

☐ Vancomycin – Resistant Gram Positive Infection (VRE)
   ☐ Enterococcus faecium (Please attach C & S results) ☐ Enterococcus faecalis (Please attach C & S results)
☐ Methacillin – Resistant Staph Aureus Infections (MRSA) (Please attach C & S results)
☐ Empiric Treatment for MRSA (**CHECK ALL THAT APPLY**)
   ☐ Previously documented MRSA infection
   ☐ Previous cellulitis caused by documented MRSA
   ☐ Skin and soft tissue infection with abscess
   ☐ Patient tried any of the following antibiotics
      ☐ Tetracycline (Dates of therapy: _____) ☐ Clindamycin (Dates of therapy: _____)
      ☐ Sulfamethoxazole/trimethoprim (Dates of therapy: _____) ☐ Any fluoroquinolone (Dates of therapy: _____)
☐ Patient with any of the following risk factor (s) (**CHECK ALL THAT APPLY**):
   ☐ Health facility stay/visit (Dates of stay: _____) ☐ HIV
   ☐ Surgery (Date of surgery: _____) ☐ Permanent indwelling catheters
   ☐ Participation in team sports (Date of most recent participation: _____) ☐ Percutaneous implanted device
   ☐ Jail/prison (Dates of stay: _____) ☐ IV drug user
   ☐ Military (Dates of service:_____) ☐ Diabetic foot ulcer
   ☐ History of "spider bite" (Date of bite:_____) ☐ End stage renal disease
   ☐ Pediatrics enrolled in daycare or school (Dates of enrollment: _____) ☐ Multiple areas of induration
   ☐ Previously colonized with multi-drug resistant pathogens including MRSA

Is this an uninterrupted continuation of Zyvox® therapy initiated in a hospital? ☐ Yes (Date therapy began: _____) ☐ No
If length of therapy is greater than twenty eight (28) days, please explain: