

# Alabama Medicaid Pharmacy Prior Authorization Request Form

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

Fax or Mail to  
Health Information Designs

P.O. Box 3210  
Auburn, AL 36823-3210

## 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-9 Code \_\_\_\_\_ Diagnosis or ICD-9 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

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD Agents                      | <input type="checkbox"/> Alzheimer's Agent   | <input type="checkbox"/> Antidepressants            | <input type="checkbox"/> Antidiabetic Agent        | <input type="checkbox"/> Antiemetic Agents |
| <input type="checkbox"/> Antihistamine                        | <input type="checkbox"/> Antihyperlipidemics | <input type="checkbox"/> Antihypertensives          | <input type="checkbox"/> Antiinfective             |  |
| <input type="checkbox"/> Anxiolytics, Sedatives and Hypnotics | <input type="checkbox"/> Cardiac Agents      | <input type="checkbox"/> EENT-Antiallergics         | <input type="checkbox"/> EENT-Vasoconstrictors     |  |
| <input type="checkbox"/> Estrogens                            | <input type="checkbox"/> H2 Antagonist       | <input type="checkbox"/> Intranasal Corticosteroids | <input type="checkbox"/> Narcotic Analgesics       | <input type="checkbox"/> NSAID             |
| <input type="checkbox"/> Platelet Aggregation Inhibitors      | <input type="checkbox"/> PPI                 | <input type="checkbox"/> Respiratory Agents         | <input type="checkbox"/> Skeletal Muscle Relaxants |  |
| <input type="checkbox"/> Skin & Mucous Membrane Agent         | <input type="checkbox"/> Triptans            | <input type="checkbox"/> 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 \_\_\_\_\_

If no previous drug usage, additional medical justification must be provided.

## 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](http://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 \_\_\_\_\_

Biological Injectables  Remicade<sup>®</sup>  Enbrel<sup>™</sup>  Kineret<sup>™</sup>  Humira<sup>™</sup>  Raptiva<sup>™</sup>  Amevive<sup>®</sup>  Orencia<sup>®</sup>  
Current weight \_\_\_\_\_ kg.

If rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis, is therapy approved by a board certified rheumatologist?  Yes  No

Prior and/or current DMARD therapy?  Yes  No If yes, attach documentation.

If Crohn's disease, is therapy approved by a board certified gastroenterologist?  Yes  No

If Remicade<sup>®</sup> is requested for rheumatoid arthritis, will patient be on Methotrexate?  Yes  No

If no, contraindication to use \_\_\_\_\_

If plaque psoriasis, is therapy approved by a board certified dermatologist?  Yes  No

If psoriatic arthritis, is therapy approved by a board certified dermatologist or rheumatologist?  Yes  No

**For Raptiva, Amevive or Enbrel**

Is the patient 18 years of age or older?  Yes  No

Is the patient with chronic moderate to severe plaque psoriasis a candidate for systemic therapy or phototherapy?  Yes  No

Has the patient failed 6 month treatment trials with topicals, generic OTC or brand, within the past year?  Yes  No

Xenical<sup>®</sup>

If initial request Weight \_\_\_\_\_ kg. Height \_\_\_\_\_ inches BMI \_\_\_\_\_ kg/m<sup>2</sup>

If renewal request Previous weight \_\_\_\_\_ kg. Current weight \_\_\_\_\_ kg.

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

Phosphodiesterase Inhibitors

Failure or inadequate response to the following alternate therapies:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

Contraindication of alternate therapies: \_\_\_\_\_

Documentation of vasoreactivity test attached

Consultation with specialist attached

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<sup>®</sup>

Current weight \_\_\_\_\_ kg.

Is treatment recommended by a board certified pulmonologist or allergist after their evaluation?  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

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

Is the patient 12 years of age or older?  Yes  No

Are the patient's baseline IgE levels between 30 IU/ml and 700 IU/ml?  Yes  No

Level: \_\_\_\_\_ Date: \_\_\_\_\_

Is the patient's weight between 30 and 150 kg?  Yes  No

**FOR HID USE ONLY**

Approve request

Deny request

Modify request

Medicaid eligibility verified

Comments \_\_\_\_\_

Reviewer's Signature \_\_\_\_\_

Response Date/Hour \_\_\_\_\_