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-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	❒ Antihistamine	❒ Antihyperlipidemics	❒ Antihypertensives	❒ Antipsychotic Agents
❒ Antiinfective	❒ Anxiolytics, Sedatives and Hypnotics		❒ Cardiac Agents	❒ EENT-Antiallergics
❒ EENT-Vasoconstrictors	❒ Estrogens	❒ H2 Antagonist	❒ Intranasal Corticosteroids	❒ Narcotic Analgesics
❒ NSAID	❒ Oral Anticoagulants	❒ Platelet Aggregation Inhibitors		❒ PPI
❒ Respiratory Agents	❒ Skeletal Muscle Relaxants	❒ Skin & Mucous Membrane Agent	❒ Triptans	❒ 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 _____

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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

Patient Medicaid # _____

❒ **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 _____

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❒ **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. _____

_____

_____

❒ **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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❒ **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 _____