Kentucky Medicaid Pharmacy Prior Authorization Form

- For Drug Requests (unless noted below) — Complete ONLY page 1 of this form.
- For ALL Opioid Requests — Complete page 1 AND page 2 of this form.
- For Hepatitis C Direct Acting Antiviral (DAA) Therapy or Synagis® Requests — Complete page 1 AND page 3 of this form.
- For Buprenorphine Products:
  - For Pain Management Diagnosis — Complete page 1 AND page 2 of this form.
  - For Substance Use Treatment— Please use the Kentucky Medicaid Substance Use Treatment Pharmacy Prior Authorization Form.

Complete each section legibly and completely. Include any supporting documents as needed (lab results, chart notes, etc.).

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 (844) 879-2961
☐ 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: City, State, Zip:	
Prescriber Specialty:	DEA:
Phone:	Fax:

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

Diagnosis:	ICD-10 Code:	Date of Diagnosis:
Medication Requested (name, strength and dosage form): *If request is for an opioid, please continue to page 2.*		
Quantity:	Days' Supply:	Expected Duration of Therapy:
Directions for Use:		

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 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 dosage of atypical antipsychotic 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 PAGE 2 **ONLY** IF REQUESTING **ANY OPIOID***

*CONTINUE TO PAGE 3 **ONLY** IF REQUESTING **HEPATITIS C DAA THERAPY** OR **SYNAGIS®***

When requesting ANY OPIOID, provide the following additional information and most recent chart/progress/clinic note:
****For members receiving hospice/palliative/end-of-life care or having a diagnosis of active cancer, this page does not need to be completed.****

INITIAL TREATMENT REQUESTS ONLY (if request is for continuation therapy skip to question 11)

Additional Diagnosis (if not stated above):	ICD-10 Code:

1. Prescriber has obtained and reviewed the KASPER report for the past 12 months? Yes No
2. Urine drug screen (UDS) has been completed within the past 30 days? **Documentation (e.g., lab result or progress note) required**
   ☐ Yes ☐ No ☐ Not Applicable (member is in a long-term care (LTC) facility or will not exceed 45 days of opioid therapy)
3. Please indicate if the patient has tried or is using any of the following non-opioid therapies:
   ☐ Exercise therapy
   ☐ Cognitive behavioral therapy
   ☐ Nonsteroidal anti-inflammatory drugs (NSAIDs) or Acetaminophen (APAP) Specify: _____
   ☐ Other: _____
4. Please indicate if the patient has any of the following baseline risk factors:
   ☐ Respiratory depression (clinically significant)
   ☐ Acute or severe bronchial asthma
   ☐ Hypercarbia (clinically significant)
   ☐ Known or suspected GI obstruction
   If any of the above are true, does the prescriber attest that benefits of opioid use outweigh the risks? Yes No
5. Prescriber has assessed baseline pain and function? ☐ Yes (Provide PEG score or documentation of physical exam) ☐ No

   EXAMPLE: ASSESSING PAIN & FUNCTION USING PEG SCALE
   PEG score = average 3 individual question scores
   Q1: *What number from 0 – 10 best describes your **pain** in the past week?*
   0 = "no pain", 10 = "worst you can imagine" 0 1 2 3 4 5 6 7 8 9 10
   Q2: *What number from 0 – 10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
   0 = "not at all", 10 = "complete interference" 0 1 2 3 4 5 6 7 8 9 10
   Q3: *What number from 0 – 10 describes how, during the past week, pain has interfered with your **general activity**?*
   0 = "not at all", 10 = "complete interference" 0 1 2 3 4 5 6 7 8 9 10

Female Patients of Child-bearing Age Only:

6. Has the patient been counseled on the risk of becoming pregnant while on this medication and the risk of neonatal abstinence syndrome?
   Yes No

Naloxone Attestation:

7. Are any of the following true?
   a. Patient UDS is positive for illicit or unexpected substances Yes **(clinical justification required)** No
   b. Morphine milligram equivalent (MME) is over 90 MME per day Yes **(clinical justification required)** No
   c. Opioid(s) is/are prescribed concurrently with benzodiazepines Yes **(clinical justification required)** No

*If yes, prescriber attests that a naloxone prescription and associated counseling on its use, was or will be **given** to the patient:* Yes No

8. Are any of the following true?
   a. Opioid(s) is/are concurrently prescribed with a skeletal muscle relaxant Yes No
   b. Opioid(s) is/are concurrently prescribed with a sedative hypnotic Yes No
   c. Opioid(s) is/are concurrently prescribed with gabapentin or pregabalin Yes No
   d. Patient has a history of opioid or other controlled substance overdose Yes No
   e. Patient has a history of substance use disorder (SUD) Yes No

*If yes, prescriber attests that a naloxone prescription and associated counseling on its use was, or will be, **offered** to the patient:* Yes No

Requests over 90 MME per day:

9. Prescriber is, or has proof of consultation with, a Pain Management Specialist OR a specialist in an appropriate discipline (e.g., orthopedist, neurologist, spine specialist, etc.) for evaluation of the source of pain and/or treatment of any underlying conditions. Yes No

Concomitant use of Opioids and Benzodiazepines:

10. Has the member and/or caregiver(s) been counseled about the increased risks of slowed or difficult breathing and/or excessive sedation, and the associated signs and symptoms? Yes No

REAUTHORIZATION (REFILL) REQUESTS ONLY (with current plan)

11. Prescriber has obtained and reviewed the KASPER report within the past 3 months? Yes No
12. Prescriber has assessed risk (check box) and documents (e.g., lab result, progress note) a urine drug screen (UDS) within the listed timeframe:
    ☐ Low Risk (12 months) ☐ Moderate Risk (6 Months) ☐ High Risk (3 Months) ☐ Not Applicable (member is in a long-term care facility)

If patient UDS is positive for illicit or unexpected substances, explanation is required, and naloxone prescription and counseling will be provided.

13. Prescriber has reassessed pain and function. Provide PEG score or clinical documentation (e.g., progress note): _____

See question 5 for example (30% improvement from baseline is clinically meaningful).

14. Has the patient required use of opioid rescue medication (e.g., naloxone), been hospitalized, or otherwise treated for opioid or other controlled substance overdose in the past 6 months? ☐ Yes **(plan for preventing future overdose required)** ☐ No

Additional Clinical Information or Medical Rationale for Request (please attach additional pages/documentation as needed):

*CONTINUE TO PAGE 3 **ONLY** IF REQUESTING **HEPATITIS C DAA THERAPY** OR **SYNAGIS®***

When requesting Hepatitis C Direct-Acting Antiviral (DAA) Therapy, provide the following additional information:

Diagnosis Criteria

Date of Hepatitis C diagnosis (or earliest record):

Female Patients of Child-bearing Age Only:
Is the patient pregnant or nursing? Yes No

Genotype/subtype:

The following documentation **must** be provided:

1. Quantitative HCV RNA level (HCV viral load) Date: _____ Result: _____
   If newly diagnosed with Hepatitis C infection within the past year, 2 HCV RNA levels must be taken at least 6 months apart to demonstrate a chronic HCV infection. Date: _____ Result: _____
2. HCV treatment status ☐ Naïve ☐ Experienced (Prior treatment regimen(s)_____)
3. Assessment of liver disease severity ☐ No cirrhosis ☐ Compensated cirrhosis (Child Pugh A) ☐ Decompensated cirrhosis (Child Pugh B or C)
4. Hepatitis B virus (HBV) screening results ☐ Positive ☐ Negative

Please provide the following information (*optional*):

5. Fibrosis (Metavir) Score _____ and Method (e.g., ultrasound, Fibroscan) _____
6. HIV screening results ☐ Positive ☐ Negative
7. Renal Impairment: ☐ None ☐ Mild to Moderate ☐ Severe ☐ Dialysis
8. Organ transplantation: ☐ Yes (specify:_____) ☐ No

Repeat DAA Therapy Questions

1. Is retreatment necessary due to treatment failure or reinfection? ☐ Treatment Failure ☐ Reinfection
2. Was the patient compliant with previous DAA therapy? Yes No
3. Were there any additional factors that led to DAA treatment failure? Yes No

If yes, how have these been addressed? _____

4. Does the patient have a recent history of alcohol or substance abuse? ☐ Yes (proceed to 4a) ☐ No (proceed to 5)
   a. Patient has completed/is participating in a recovery program, receiving alcohol or substance abuse counseling services, or seeing an addiction specialist as part of HCV treatment? ☐ Yes ☐ No
5. Patient is willing and able to comply with requirements of the retreatment plan? Yes No
6. Patient has been educated regarding risk behaviors associated with HCV infection? Yes No

When requesting Synagis®, provide the following additional information:

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

Note: Synagis is available in 50mg and 100mg vials. Always coordinate dosing appropriately to reduce waste.

1. Patient's gestational age at birth: _____ weeks _____ days
2. Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)?
   ☐ Yes (proceed to 2a) ☐ No (proceed to 3)
   a. Did the patient receive oxygen immediately following birth? ☐ Yes (proceed to 2b) ☐ No (proceed to 3)
   b. Please indicate the % oxygen received: _____ Date received: _____ Duration of treatment: _____
3. Does the patient have a diagnosis of Cystic Fibrosis? ☐ Yes (proceed to 3a) ☐ No (proceed to 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 the 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 the 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 pharmaceutical therapies for cardiovascular disease and the most recent date administered:
   Cardiovascular medication(s): _____ Most recent date administered: _____
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