

# 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 36832-3210**

### 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:**  Amevive®  Enbrel®  Humira®  Kineret®  Orencia®  Raptiva®  Remicade®  Simponi®

Current Weight \_\_\_\_\_ kg

For **rheumatoid arthritis (RA)**, **juvenile idiopathic arthritis (JIA)**, and **ankylosing spondylitis (AS)**, is therapy approved by a board certified rheumatologist **or** for **psoriatic arthritis (PA)**, is therapy approved by a board certified dermatologist or rheumatologist?  Yes  No

- For **RA, JIA, AS**, or **PA** diagnosis, has the patient failed a 30-day treatment trial with at least one conventional DMARD? If yes, attach documentation.  Yes  No
- For newly diagnosed **RA**, does the patient have high disease activity for < 3 months with features of a poor prognosis **and** therapy is being initiated with methotrexate **and** either Enbrel or Humira? If yes, indicate specific markers, values and features.  Yes  No
- For Remicade and Simponi, will patient be on methotrexate? If no, include contraindications to use.  Yes  No

For **Crohn's disease (CD)** or **ulcerative colitis (UC)**, is therapy approved by a board certified gastroenterologist?  Yes  No

- For **CD** or **UC** diagnosis, has the patient failed a 30-day treatment trial with at least one or more conventional therapies? If yes, attach documentation.  Yes  No

For **plaque psoriasis (PP)**, is therapy approved by a board certified dermatologist?  Yes  No

- For **PP** diagnosis, is the patient > 18 years of age?  Yes  No
- Has the patient had an inadequate response to systemic therapy or phototherapy?  Yes  No
- Has the patient failed a 6 month treatment trial with topical treatments (generic, OTC, or brand) within the past year? If yes, attach documenttion  Yes  No
- For Amevive, has there been 12 weeks since the initial request?  Yes  No

**Xenical<sup>R</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. \_\_\_\_\_

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>R</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