

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:
	<input type="checkbox"/> Fee-For-Service (Magellan)	1 (800) 477-3071	1 (800) 365-8835
	<input type="checkbox"/> Anthem Medicaid	1 (855) 661-2028	1 (844) 879-2961
	<input type="checkbox"/> Aetna Better Health	1 (855) 300-5528	1 (855) 799-2550
	<input type="checkbox"/> Humana	1 (800) 555-2546	1 (877) 486-2621
	<input type="checkbox"/> UHC Community Plan of Kentucky	1 (810) 310-6826	1 (866) 940-7328
<input type="checkbox"/> WellCare of Kentucky	1 (877) 389-9457	1 (855) 620-1868	

Patient Information:

Member Name:		Date of Birth:	
Address: City, State, Zip:			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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): <i>If request is for an opioid, please continue to page 2.</i>		
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: <input type="checkbox"/> Prescriber <input type="checkbox"/> 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 and Simplified Treatment Eligibility	Date of Hepatitis C diagnosis (or earliest record): _____	Female Patients of Child-bearing Age Only: Is the patient pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>1. Quantitative HCV RNA level (HCV viral load) Date: _____ Result: _____ <i>If newly diagnosed with Hepatitis C infection within the past year, two HCV RNA levels must be taken at least 6 months apart to demonstrate a chronic HCV infection.</i> Date: _____ Result: _____</p> <p>2. Which of the following applies to this patient?</p> <p>a. Previously treated for Hepatitis C? If so, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No (treatment-naïve)</p> <p>b. Cirrhosis (FIB-4 score > 3.25 or other clinical indicators)? <input type="checkbox"/> Yes <input type="checkbox"/> No cirrhosis (FIB-4 score < 3.25)</p> <p style="margin-left: 20px;">▪ If 'No', FIB-4 score (https://www.hepatitisc.uw.edu/page/clinical-calculators/fib-4) is: _____</p> <p style="margin-left: 20px;">▪ If 'Yes', is it <input type="checkbox"/> compensated (Child Pugh A) or <input type="checkbox"/> decompensated (Child Pugh B or C) cirrhosis?</p> <p>c. Human immunodeficiency virus (HIV) positive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Hepatitis B surface antigen (HBsAg) positive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. History of liver transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Known or suspected hepatocellular carcinoma (HCC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. If 'No' to all of the above, the patient is eligible for simplified treatment; stop here. If 'Yes', proceed to question 4.</p> <p>4. If 'Yes' to any of the items above, the patient is NOT eligible for simplified treatment; please provide the following:</p> <p>a. HCV genotype: _____</p> <p>b. Prior HCV treatment experience (medication/dates; if applicable): _____</p> <p>c. Prescriber qualification/specialty: <input type="checkbox"/> HCV academic/mentorship program or network (e.g., KHAMP, ECHO)</p> <p><input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hepatology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> HIV Specialist (AAHIVS) <input type="checkbox"/> Transplant</p>	

Repeat DAA Therapy Questions (complete only if requesting repeated DAA therapy)	<p>1. Is retreatment necessary due to treatment failure or reinfection? <input type="checkbox"/> Treatment Failure <input type="checkbox"/> Reinfection</p> <p>2. Was the patient compliant with previous DAA therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Were there any additional factors that led to DAA treatment failure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, how have these been addressed?</i> _____</p> <p>4. Does the patient have a recent history of alcohol or substance abuse? <input type="checkbox"/> Yes (proceed to 4a) <input type="checkbox"/> No (proceed to 5)</p> <p style="margin-left: 20px;">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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Patient is willing and able to comply with requirements of the retreatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Patient has been educated regarding risk behaviors associated with HCV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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When requesting Synagis®, provide the following additional information:

Note: Therapy may begin November 1 with last date of therapy no later than March 31 (end of RSV season).

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:

<input type="checkbox"/> Anatomic Pulmonary Abnormality	Specify: _____
<input type="checkbox"/> Neuromuscular Disorder	Specify: _____
<input type="checkbox"/> Congenital anomaly that impairs the ability to clear secretions	Specify: _____
5. Please indicate if the patient has any of the following:

<input type="checkbox"/> HIV	<input type="checkbox"/> Cancer, receiving chemotherapy	<input type="checkbox"/> Organ transplant receiving immunosuppressant therapy or hematopoietic stem cell transplant
<input type="checkbox"/> 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

<input type="checkbox"/> Acyanotic heart disease	Specify: _____
<input type="checkbox"/> Cyanotic heart disease	Specify: _____
<input type="checkbox"/> Pulmonary Hypertension	Name of Pediatric Cardiologist: _____
<input type="checkbox"/> 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