BENZODIAZEPINES
PRIOR AUTHORIZATION FORM

NOTES:

- **Prescribers: To avoid filling out and submitting this form** for preferred drugs, write the diagnosis code on the face of the prescription to allow an automated Prior Authorization (PA) at the pharmacy.
- **Pharmacists: To enable automated PA**, please enter the diagnosis code at the point of sale.
- Alprazolam IR tablets are preferred, all other dosage forms are non-preferred.
- Preferred Benzodiazepines are available without a prior authorization for the first 60 days per 365-day period. This criteria applies to therapy beyond 60 days.
- Please refer to the Clinical Criteria for Opioids and Benzodiazepines at https://kyportal.medimpact.com/ for additional information if the following apply:
  - concurrent treatment with opioid(s)
  - diagnosis other than those in the criteria below
- When complete, please fax to **Kentucky MCO PA Fax: 1-858-357-2612**
- Kentucky MCO PA Phone: 1-844-336-2676

Drug Name:	Permission to substitute the preferred product (eg alprazolam IR for Xanax IR) ☐ Yes ☐ No
Quantity:	Days Supply:
Directions for Use:	
Member Name:	Member ID:
Member Date of Birth:	Member Age:
Member Address:	
Sex: ☐ Male ☐ Female	Member's ICD Code or Diagnosis:

Requester: ☐ Prescriber's office ☐ Pharmacy	Your name:
Prescriber / Pharmacy Name:	
Prescriber / Pharmacy Address:	
If a Prescriber, Specialty:	Prescriber / Pharmacy NPI:
Prescriber Phone:	Prescriber Fax:
Pharmacy Phone:	Pharmacy Fax:
On behalf of the Prescriber, I certify that the information in this form is true, made to allow Kentucky Medicaid to offer prescription coverage to the member for the medication requested. I understand the health plan will retain this document and any attached materials for the purpose of possible future audit(s).	
Your Signature:	Date:

GENERAL QUESTIONS FOR ALL REQUESTS

Are you requesting a brand or non-preferred product?	☐ Yes ☐ No
If you ARE requesting a non-preferred product, has the patient had a trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of TWO preferred products?	☐ Yes ☐ No
If you ARE requesting a brand product, has the patient tried and failed (e.g., allergy or intolerance to an inactive ingredient) TWO manufacturers of the corresponding generic?	☐ Yes ☐ No
What is the patient's diagnosis? ICD-10 and description	
Is the patient expected to require more than 60 days of benzodiazepine therapy?	☐ Yes ☐ No