# 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, 2,3 AND page 4 of this form.
- For Hepatitis C Direct Acting Antiviral (DAA) Therapy — Complete page 1 AND page 5 of this form.
- For Synagis® Requests — Complete page 1 AND page 6 of this form
- For Buprenorphine Products:
  - For Pain Management Diagnosis — Complete page 1 AND page 2 of this 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.**

| **Plan:** | **Phone number:** | **Fax number:** |
|---|---|---|
| All Kentucky MCO Plans (MedImpact) | 1 (844) 336-2676 | 1 (858) 357-2612 |

**Patient Information:**

| | | |
|---|---|---|
| Member Name: | Date of Birth: | |
| Address:<br>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):<br>*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 answer the following questions:*

1) *Has the member tried 2 generic manufactures* ☐Yes ☐No
2) *Please provide medical justification why the patient cannot be appropriately treated with the generic form of the drug.(allergy, intolerance to inactive ingredient)*_____

**Please indicate previous treatment outcomes below:**

| Previous Medication | Strength | Quantity | Directions (Sig) | Dates (from and to) | Reason for Discontinuation |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Refer to link for List of Preferred Agents:
https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/PreferredDrugGuide_full.pdf

☐Patient recently hospitalized

*If requesting antibiotics, anti-infective, antidepressants, anticonvulsants, antipsychotic for discharge to complete the course of prescription, provide duration:_____ (original + refills)*

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 5 **ONLY** IF REQUESTING **HEPATITIS C DAA THERAPY** OR CONTINUE TO PAGE 6 IF REQUESTING **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.****
**PLEASE NOTE: ALL OPIOID PA REQUESTS MUST BE COMPLETED BY THE PRESCRIBER ONLY**

**INITIAL TREATMENT REQUESTS ONLY (if request is for continuation therapy skip to question 35)**

| 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
6. Does the patient meet ONE of the following criteria?
   a. The patient is receiving hospice, palliative, or end-of-life care ☐Yes ☐No
   b. The patient has a diagnosis of active cancer ☐Yes ☐No
   c. The patient has a diagnosis of sickle cell anemia ☐Yes ☐No
7. Does the patient have a diagnosis of severe pain requiring daily, around-the-clock, long-term pain management? ☐Yes ☐No
   If 'Yes', proceed to 7a, if 'No' proceed to 8
   a. The patient's pain lasts: > 3 consecutive months ☐Yes ☐No, or > 6 consecutive months ☐Yes ☐No
   b. The patient had a trial and failure within the past 90 days of 1 non-opioid analgesic (i.e., NSAIDs, APAP) at maximum tolerated doses without pain relief and/or functional improvement ☐Yes ☐No
   c. The patient had a trial and failure within the past 90 days of at least 1 short acting opioid analgesic at maximum tolerated doses without adequate relief of pain ☐Yes ☐No
8. Does the patient have a diagnosis of diabetic peripheral neuropathy? ☐Yes ☐No If 'Yes' proceed to 8a, if 'No' proceed to 9
   a. The patient had a trial and failure of ONE serotonin-norepinephrine reuptake inhibitor (SNRI; such as duloxetine) ☐Yes ☐No
   b. The patient had a trial and failure of ONE tricyclic antidepressant (TCA; such as amitriptyline) ☐Yes ☐No
9. Does the patient have a diagnosis of neonatal abstinence syndrome (NAS) and meet the following criteria? The patient is being discharged from the hospital on a methadone taper ☐Yes ☐No
10. The prescriber has proof of consultation with a pain management specialist ☐Yes ☐No OR 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
11. The patient does NOT have a history of drug or alcohol abuse/dependence or addiction (drug and alcohol toxicology screen results dated within the past month must be submitted with the PA request) ☐Yes ☐No
12. The patient is NOT using more than 1 long-acting opioid and 1 short-acting opioid at a time ☐Yes ☐No
13. The patient has ONE of the following headache disorders: Muscular headache, Tension-type headache, or Migraine ☐Yes ☐No
14. For a high strength (e.g., hydromorphone 8mg) or concentrated dosage form (e.g., morphine sulfate 20 mg/mL, oxycodone 20 mg/mL), please submit a rationale as to why lower strength or less-concentrated products cannot be used _____
15. Is the patient opioid naive (defined as ≤ 14 days of opioid use in the past 90 days)? ☐Yes ☐No If 'Yes', proceed to 15a, if 'No' proceed to 16
    a. The patient is using only 1 short-acting opioid at a time ☐Yes ☐No
    b. Prescribed by a treating physician within 14 days of ONE of the following: major surgery, any operative or invasive procedure or a delivery, significant trauma, being any acute blunt, blast, or penetrating bodily injury that has a risk of death, physical disability, or impairment ☐Yes ☐No
    c. If treatment with opioids should extend beyond 14 days please provide clinical justification_____
16. Is Long-term (> 3 months) pain management expected or indicated ☐Yes ☐No
17. For non-preferred **long acting** opioids: Does the patient have a > 1 month trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to TWO preferred agents ☐Yes ☐No, if 'Yes' please see question 22.

18. For non-preferred **short acting** opioids: The patient had at least a 1-week trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to TWO preferred agents ☐Yes ☐No If 'Yes' please see question 22
19. Does the patient have a diagnosis of cancer pain and meet the following criteria? The patient has been receiving opioid doses greater than or equal to 60 morphine milligram equivalents (MME) per day (e.g., morphine sulfate 60 mg, fentanyl patch 50 mcg/hr, 16 mg hydromorphone, etc.) for at least one week prior to the PA request ☐Yes ☐No
20. If opioid MME exceeding 90 MME per day please provide clinical justification _____
21. For opioid MME exceeding 200 MME per day please submit documentation (e.g., progress notes) showing attempts and/or plans to taper below 200 MME/day as well as other non-opioid components (e.g., NSAIDs, physical therapy, etc.) of the treatment plan
22. For tried and failed medications please provide the following information:
    Medication name, strength, dosage _____
    Specific start date _____
    Specific end date _____

**Female Patients of Child-bearing Age Only:**

23. 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:**

24. 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

25. 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

26. For non-preferred agents: Please provide clinical rationale to constitute the use of the requested formulation_____

**Requests over 90 or 200 MME per day:**

27. For requests over 90 MME: 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
28. For requests over 200 MME: The prescriber is, or has proof of consultation with, a Pain Management Specialist ☐Yes ☐No
29. Clinical justification for exceeding 90 or 200 MME per day _____
30. Prescriber attests that a naloxone prescription and associated counseling on its use was or will be offered to the member ☐Yes ☐No
31. For requests over 200 MME: prescriber submitted documentation (e.g., progress notes) showing attempts and/or plans to taper below 200 MME/day as well as other non-opioid components (e.g., NSAIDs, physical therapy, etc.) of the treatment plan

**Concomitant use of Opioids and Benzodiazepines:**

32. 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
33. The prescriber attests that a naloxone prescription and associated counseling on its use was or will be given to the member ☐Yes ☐No
34. Clinical justification for the concurrent use of benzodiazepine(s) and opioid(s) _____

**REAUTHORIZATION (REFILL) REQUESTS ONLY (with current plan)**
**PLEASE NOTE: ALL OPIOID PA REQUESTS MUST BE COMPLETED BY THE PRESCRIBER ONLY**

35. Does the patient meet ONE of the following criteria?
    a. The patient is receiving hospice, palliative, or end-of-life care ☐Yes ☐No
    b. The patient has a diagnosis of active cancer ☐Yes ☐No
    c. The patient has a diagnosis of sickle cell anemia ☐Yes ☐No
36. Prescriber has obtained and reviewed the KASPER report within the past 3 months? ☐Yes ☐No
37. Urine drug screen (UDS) results: ☐Positive ☐Negative Date: _____
38. 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)
39. If patient UDS is positive for illicit or unexpected substances:
    a. Please provide explanation _____
    b. Will naloxone prescription and counseling be provided ☐Yes ☐No
40. Prescriber has reassessed pain and function. Provide PEG score _____or clinical documentation (e.g., progress note): _____
41. The patient has demonstrated a 30% improvement from baseline to continue current dose ☐Yes ☐No
    OR includes the rationale for continued opioid therapy at the current dose _____
42. 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 *If 'Yes'* ***please provide plan for preventing future overdose*** ☐No

**Female Patients of Child-bearing Age Only:**

43. Does the PRESCRIBER attest that the patient has been counseled on the risk of becoming pregnant while on this medication and the risk of neonatal abstinence syndrome? ☐Yes ☐No

**Requests over 90 or 200 MME per day:**

44. For requests over 90 MME: 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
45. For requests over 200 MME: The prescriber is, or has proof of consultation with, a Pain Management Specialist ☐Yes ☐No
46. Clinical justification for exceeding 90 or 200 MME per day _____
47. Prescriber attests that a naloxone prescription and associated counseling on its use was or will be offered to the member ☐Yes ☐No
48. For requests over 200 MME: prescriber submitted documentation (e.g., progress notes) showing attempts and/or plans to taper below 200 MME/day as well as other non-opioid components (e.g., NSAIDs, physical therapy, etc.) of the treatment plan

**Concomitant use of Opioids and Benzodiazepines:**

49. Does the PRESCRIBER attest that 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
50. The prescriber attests that a naloxone prescription and associated counseling on its use was or will be given to the member ☐Yes ☐No
51. Clinical justification for the concurrent use of benzodiazepine(s) and opioid(s) _____

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

*CONTINUE TO PAGE 5* ***ONLY*** *IF REQUESTING* ***HEPATITIS C DAA THERAPY*** *OR CONTINUE TO PAGE 6 IF REQUESTING* ***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:**<br>Is the patient pregnant or nursing? ☐Yes ☐No<br><br>If yes, Prescriber attests that the benefits of HCV treatment outweigh potential risks ☐Yes ☐No |
| | 1. Quantitative HCV RNA level (HCV viral load) (must be within 3 months) Date: _____ Result: _____<br>2. Which of the following applies to this patient?<br>a. Previously treated for Hepatitis C? If so, provide details below. ☐Yes ☐No (treatment-naïve)<br>b. Cirrhosis (FIB-4 score > 3.25 or other clinical indicators)? ☐Yes ☐No cirrhosis (FIB-4 score < 3.25)<br>• If 'No', FIB-4 score (https://www.hepatitisc.uw.edu/page/clinical-calculators/fib-4) is: _____<br>• If 'Yes', is it ☐compensated (Child Pugh A) or ☐decompensated (Child Pugh B or C) cirrhosis?<br>c. Human immunodeficiency virus (HIV) positive? ☐Yes ☐No<br>d. Hepatitis B surface antigen (HBsAg) positive? ☐Yes ☐No<br>e. History of liver transplant? ☐Yes ☐No<br>f. Known or suspected hepatocellular carcinoma (HCC)? ☐Yes ☐No<br>3. If 'No' to all of the above, the patient is eligible for simplified treatment; stop here. If 'Yes', proceed to question 4.<br>4. If 'Yes' to any of the items above, the patient is NOT eligible for simplified treatment; please provide the following:<br>a. HCV genotype: _____ subtype_____ resistance mutations_____<br>b. Prior HCV treatment experience (medication/dates; if applicable): _____<br>5. Prescriber qualification/specialty: ☐HCV academic/mentorship program or network (e.g., KHAMP, ECHO) ☐Gastroenterology ☐Hepatology ☐Infectious Disease ☐HIV Specialist (AAHIVS) ☐Transplant<br>6. Is the prescribed treatment regimen included in the requested drug's package insert and/or supported by current HCV guidelines for the patient's age/weight ☐Yes ☐No<br>7. For nonpreferred drugs: is there clinical justification (e.g., allergy, contraindication, potential drug-drug interactions with other medications, or intolerance) as to why preferred drugs cannot be used or are not indicated:_____<br>8. Was the patient previously treated with a direct-acting antiviral? ☐Yes ☐No<br>If 'No'; stop here. If 'Yes', proceed to Repeat DAA Therapy Questions. | |
| **Repeat DAA Therapy Questions**<br><br>**(complete only if requesting repeated DAA therapy)** | 1. Is retreatment necessary due to treatment failure or reinfection? ☐Treatment Failure ☐Reinfection<br>2. Was the patient compliant with previous DAA therapy? ☐Yes ☐No (if no justification must be provided: _____)<br>3. Were there any additional factors that led to DAA treatment failure? ☐Yes ☐No<br>*If yes, how have these been addressed?* _____<br>4. Does the patient have a recent history of alcohol or substance abuse? ☐Yes (proceed to 4a) ☐No (proceed to 5)<br>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<br>b. Patient has been evaluated for alcohol and substance abuse using a validated screening tool ☐Yes ☐No<br>c. Patient is not actively participating in illicit substance use or alcohol abuse with confirmatory laboratory testing (e.g., urine drug screen) ☐Yes ☐No<br>5. Patient is willing and able to comply with requirements of the retreatment plan? ☐Yes ☐No<br>6. Patient has been educated regarding risk behaviors associated with HCV infection? ☐Yes ☐No<br>7. The prescriber has addressed any factors that may have led to noncompliance with previous treatment(s) ☐Yes ☐No | |

**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.**

**PA requests may be accepted beginning October 1 (for a November 1 effective date).**

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: _____
   c. Does the patient require medical support (chronic systemic steroids, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season? ☐Yes ☐No
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 and/or nutritional compromise? ☐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