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

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

Plan:	**Phone number:**	**Fax number:**
☐ MCO Member	(844) 336-2676	(858) 357-2612
☐ FFS Member	(877) 403-6034	

Member Information:

Member Name:	Date of Birth:	
Address: City, State, Zip:		
Sex:	Height:	Weight:
Member ID:	Medication Allergies:	

Prescriber Information:

Prescriber Name:	NPI:
Prescriber Address: City, State, Zip:	
Prescriber Specialty:	DEA:
Phone:	Fax:

Pharmacy Information (If this request is made by the pharmacy)

Pharmacy Name:	NPI:
Phone:	Fax:

Diagnosis and Medical Information for Requested Medication: ☐ INITIAL REQUEST ☐ REAUTHORIZATION (REFILL)

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:		

☐Continuation of Care from recent hospitalization

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

Rationale for Prior Authorization:

Brand Medically Necessary? ☐Yes ☐No *If yes, please answer the following questions:*

1) Has the member tried 2 generic manufacturers ☐Yes ☐No

*2) Please provide medical justification why the member cannot be appropriately treated with the generic form of the drug (allergy, intolerance to inactive ingredient)*_____

Pharmacy Coverage vs Medical: ** Medical Coverage FFS Contact Gainwell at 800-807-1232**

Request override for Pharmacy Coverage vs Medical? ☐Yes ☐No *If yes, please answer the following questions:*

1) Does the prescriber attend medication is being self-administered AND appropriate per dosage and administration section of the package insert? ☐Yes ☐No
2) Is the medication being administered by a home infusion provider? ☐Yes ☐No
3) Is the medication being used for a compound in compliance with USP 795, or 797, standards for compounding? ☐Yes ☐No

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

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 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, only question 1 needs 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 30)

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

1. Does the member meet ONE of the following criteria?
   a. The member is receiving hospice, palliative, or end-of-life care ☐Yes ☐No
   b. The member has a diagnosis of active cancer ☐Yes ☐No
   c. The member has a diagnosis of sickle cell anemia ☐Yes ☐No
2. Does the member reside in an LTC facility? ☐Yes ☐No
3. Prescriber has obtained and reviewed the KASPER report for the past 12 months? ☐Yes ☐No
4. Urine drug screen (UDS) has been completed within the past 30 days? **Documentation (e.g., lab result or progress note) required.**
   ☐Yes ☐No
5. Please indicate if the member 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: _____
6. Please indicate if the member 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
7. Has prescriber assessed baseline pain and function based on an objective measure? ☐Yes ☐No
8. Does the member have a diagnosis of severe pain requiring daily, around-the-clock, long-term pain management? ☐Yes ☐No
   If 'Yes', proceed to 8a, if 'No' proceed to 9
   a. The member's pain lasts: > 3 consecutive months ☐Yes ☐No, or > 6 consecutive months ☐Yes ☐No
   b. The member 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 member 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
9. Does the member have a diagnosis of diabetic peripheral neuropathy? ☐Yes ☐No If 'Yes' proceed to a, if 'No' proceed to 10
   a. The member had a trial and failure of ONE serotonin-norepinephrine reuptake inhibitor (SNRI, such as duloxetine) ☐Yes ☐No
   b. The member had a trial and failure of ONE tricyclic antidepressant (TCA, such as amitriptyline) ☐Yes ☐No
10. Does the member have a diagnosis of neonatal abstinence syndrome (NAS) and meet the following criteria? The member is being discharged from the hospital on a methadone taper ☐Yes ☐No
11. 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
12. The member 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
13. The member is NOT using more than 1 long-acting opioid and 1 short-acting opioid at a time ☐Yes ☐No
14. Is the member opioid naive (defined as ≤ 14 days of opioid use in the past 90 days)? ☐Yes ☐No If 'Yes', proceed to 14a, if 'No' proceed to 15
   a. The member is using only 1 short-acting opioid at a time ☐Yes ☐No
   b. Prescribed by a treating prescriber 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:
      _____
      _____
15. Is Long-term (> 3 months) pain management expected or indicated ☐Yes ☐No
16. For non-preferred **long-acting** opioids: Does the member have a > 1 month trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to TWO preferred agents ☐Yes ☐No If 'Yes' proceed to 18
17. For non-preferred **short acting** opioids: The member had at least a 1-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to TWO preferred agents ☐Yes ☐No If 'Yes' proceed to 18
18. For tried and failed medications please provide the following information:
    Medication name, strength, dosage _____
    Specific start date _____
    Specific end date _____

Female Members of Child-bearing Age Only:

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

Naloxone Attestation:

20. Has the member had a UDS is positive for illicit or unexpected substance ☐Yes ☐No
    a. *If yes, prescriber attests that a naloxone prescription and associated counseling on its use, was or will be **given** to the member:* ☐Yes ☐No
21. Are any of the following true?
    b. Opioid(s) is/are concurrently prescribed with a skeletal muscle relaxant ☐Yes ☐No
    c. Opioid(s) is/are concurrently prescribed with a sedative hypnotic ☐Yes ☐No
    d. Opioid(s) is/are concurrently prescribed with gabapentin or pregabalin ☐Yes ☐No
    e. Member has a history of opioid or other controlled substance overdose ☐Yes ☐No
    f. Member 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 member:* ☐Yes ☐No

Requests over 90 or 200 MME per day:

22. 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
23. For requests over 200 MME: The prescriber is, or has proof of consultation with, a Pain Management Specialist ☐Yes ☐No
24. Clinical justification for exceeding 90 or 200 MME per day _____
25. Prescriber attests that a naloxone prescription and associated counseling on its use was or will be offered to the member ☐Yes ☐No
26. 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:

27. 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
28. The prescriber attests that a naloxone prescription and associated counseling on its use was or will be given to the member ☐Yes ☐No
29. 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

30. Does the member meet ONE of the following criteria?
    a. The member is receiving hospice, palliative, or end-of-life care ☐Yes ☐No
    b. The member has a diagnosis of active cancer ☐Yes ☐No
    c. The member has a diagnosis of sickle cell anemia ☐Yes ☐No
31. Prescriber has obtained and reviewed the KASPER report within the past 3 months? ☐Yes ☐No
32. Urine drug screen (UDS) results: ☐Positive ☐Negative Date: _____
33. 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)
34. If member UDS is positive for illicit or unexpected substances:
    a. Please provide explanation _____
    b. Will naloxone prescription and counseling be provided ☐Yes ☐No
35. Prescriber has reassessed pain and function. ☐Yes ☐No
36. The member 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 _____
37. Has the member 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 Members of Child-bearing Age Only:

38. Does the PRESCRIBER attest that the member 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:

39. 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
40. For requests over 200 MME: The prescriber is, or has proof of consultation with, a Pain Management Specialist ☐Yes ☐No
41. Clinical justification for exceeding 90 or 200 MME per day _____
42. Prescriber attests that a naloxone prescription and associated counseling on its use was or will be offered to the member ☐Yes ☐No
43. 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:

44. 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
45. The prescriber attests that a naloxone prescription and associated counseling on its use was or will be given to the member ☐Yes ☐No
46. 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 Members of Child-bearing Age Only:
Is the member pregnant or nursing? ☐Yes ☐No

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: _____
2. Which of the following applies to this member?
   a. Previously treated for Hepatitis C? If so, provide details below. ☐Yes ☐No (treatment-naïve)
   b. Cirrhosis (FIB-4 score > 3.25 or other clinical indicators)? ☐Yes ☐No cirrhosis (FIB-4 score < 3.25)
      - If 'No', FIB-4 score (https://www.hepatitisc.uw.edu/page/clinical-calculators/fib-4) is: _____
      - If 'Yes', is it ☐compensated (Child Pugh A) or ☐decompensated (Child Pugh B or C) cirrhosis?
   c. Human immunodeficiency virus (HIV) positive? ☐Yes ☐No
   d. Hepatitis B surface antigen (HBsAg) positive? ☐Yes ☐No
   e. History of liver transplant? ☐Yes ☐No
   f. Known or suspected hepatocellular carcinoma (HCC)? ☐Yes ☐No
3. If 'No' to all of the above, the member is eligible for simplified treatment; stop here. If 'Yes', proceed to question 4.
4. If 'Yes' to any of the items above, the member is NOT eligible for simplified treatment; please provide the following:
   a. HCV genotype: _____ subtype_____ resistance mutations_____
   b. Prior HCV treatment experience (medication/dates; if applicable): _____
5. Prescriber qualification/specialty: ☐HCV academic/mentorship program or network (e.g., KHAMP, ECHO) ☐Gastroenterology ☐Hepatology ☐Infectious Disease ☐HIV Specialist (AAHIVS) ☐Transplant
6. Is the prescribed treatment regimen included in the requested drug's package insert and/or supported by current HCV guidelines for the member's age/weight ☐Yes ☐No
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:_____
8. Was the member previously treated with a direct-acting antiviral? ☐Yes ☐No
   If 'No'; stop here. If 'Yes', proceed to Repeat DAA Therapy Questions.

Repeat DAA Therapy Questions

(complete only if requesting repeated DAA therapy)

1. Is retreatment necessary due to treatment failure or reinfection? ☐Treatment Failure ☐Reinfection
2. Was the member compliant with previous DAA therapy? ☐Yes ☐No (if no justification must be provided: _____)
3. Were there any additional factors that led to DAA treatment failure? ☐Yes ☐No
   *If yes, how have these been addressed?*_____
4. Does the member have a recent history of alcohol or substance abuse? ☐Yes (proceed to 4a) ☐No (proceed to 5)
   a. Member 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
   b. Member has been evaluated for alcohol and substance abuse using a validated screening tool ☐Yes ☐No
   c. Member is not actively participating in illicit substance use or alcohol abuse with confirmatory laboratory testing (e.g., urine drug screen) ☐Yes ☐No
5. Member is willing and able to comply with requirements of the retreatment plan? ☐Yes ☐No
6. Member has been educated regarding risk behaviors associated with HCV infection? ☐Yes ☐No
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: Unless otherwise noted by DMS, 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. Member's gestational age at birth:_____weeks_____days
2. Does the member have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)?
   ☐Yes (proceed to 2a) ☐No (proceed to 3)
   a. Did the member 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 member 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 member have a diagnosis of Cystic Fibrosis? ☐Yes (proceed to 3a) ☐No (proceed to 4)
   a. Has the member been hospitalized for a pulmonary exacerbation? ☐Yes (Date:_____) ☐No
   b. Does the member have clinical evidence of chronic lung disease and/or nutritional compromise? ☐Yes ☐No
   c. Does the member have clinical evidence of failure to thrive? ☐Yes ☐No
   d. Does the member have pulmonary abnormalities on chest X-ray or CT that persist when the member is stable? ☐Yes ☐No
   e. What is the member's weight for length percentile? _____
4. Please indicate if the member 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 member 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 member received a heart transplant? ☐Yes (Date:_____) ☐No
7. Does member 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 member'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 member had an ECMO or cardiac bypass during the RSV season?
    ☐Yes (Date:_____) ☐No
11. Has the patient received a dose of Beyfortus (nirsevimab) during the current RSV season? ☐Yes ☐No