maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Daybue

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Rett Syndrome (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the requested medication being prescribed by or in consultation with a neurologist? [If no, no further questions.]	Yes	No
3	Has documentation been provided to confirm that the patient does not have moderate to severe renal impairment, patient has GFR GREATER THAN 30mL/min/m2? ACTION REQUIRED: Submit supporting documentation.	Yes	No

If you have any questions, call:
1-888-258-8250

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	[If no, no further questions.]		
4	Is the patient currently receiving the requested medication? [If no, skip to question 10.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 10.]	Yes	No
7	Has documentation been provided to confirm that clinical responses of the patient's condition has improved or stabilized based upon the prescriber's assessment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has documentation been provided to confirm that the patient has improved clinical measurable symptoms: decreased Rett Syndrome Behaviour Questionnaire (RSBQ) and Clinical Global Impression-Improvement (CGI-I) score by 1 to 4 points after 12 weeks of treatment? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has documentation been provided to confirm that the patient has lack of severe weight loss, LESS THAN 5% from baseline? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
10	Is the patient greater than or equal to 2 year(s) of age? [If no, no further questions.]	Yes	No
11	Has documentation been provided to confirm that the patient has a pathogenic mutation in the MECP2 gene? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has classic/typical Rett syndrome, according to the Rett Syndrome Diagnostic Criteria? ACTION REQUIRED: Submit supporting documentation. [Note: The diagnosis of classic/typical Rett syndrome requires all main diagnostic criteria and none of the exclusion criteria. The main Rett syndrome diagnostic criteria are: 1) partial or complete loss of acquired purposeful hand skills; 2) partial or complete loss of acquired spoken language; 3) gait abnormalities [for example, impaired (dyspraxic) or absence of ability]; and 4) stereotypic hand movements,	Yes	No

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	such as hand wringing/squeezing, clapping/tapping, mouthing and washing/rubbing automatisms. The exclusion criteria for classic/typical Rett syndrome are: 1) brain injury secondary to trauma (peri- or postnatally), neurometabolic disease, or severe infection that causes neurological problems; and 2) grossly abnormal psychomotor development in first 6 months of life.] [If no, no further questions.]		
13	Has documentation been provided to confirm that the patient has documented baseline disease severity of behavior and/or functionality using an objective measure or tool [for example, Clinical Global Impression-Improvement (CGI-I) score, Motor-Behavior Assessment (MBA)]? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient is past the initial period of regression (that is, no additional loss or degradation in ambulation, hand function, speech, or nonverbal communicative or social skills within 6 months of initial period of regression), according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation has been provided to confirm that the patient has had no seizures or has a stable pattern of seizures (for example, no changes in seizure frequency, antiepileptic drugs, or behavioral treatments)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the patient has documented baseline weight and does not have progressive weight loss prior to therapy initiation? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Does the requested dose exceed Food and Drug Administration approved label dosing for the requested indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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