maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tranexamic Acid

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 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 9)

2 What is the indication or diagnosis?
[] Cyclic heavy menstrual bleeding (If checked, go to 3)

[] Hemophilia (If checked, go to 8)

[] All other indications/diagnosis (If checked, no further questions)

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

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3	Is the patient 12 years of age OR older? [If no, no further questions.]	Yes	No
4	Has the patient tried and failed oral non-steroidal anti-inflammatory drugs (NSAIDs)? [If yes, skip to question 6.]	Yes	No
5	Does the patient have an intolerance or contradiction to oral non-steroidal anti-inflammatory drugs (NSAIDs)? [If no, no further questions.]	Yes	No
6	Has the patient tried and failed ANY of the following medications: A) oral hormonal cycle control combinations, B) oral progesterone, C) Mirena, D) Depo Provera? [If yes, no further questions.]	Yes	No
7	Does the patient have an intolerance or contradiction to ANY of the following medications: A) oral hormonal cycle control combinations, B) oral progesterone, C) Mirena, D) Depo Provera? [No further questions.]	Yes	No
8	Is the requested medication being used for the treatment of acute bleeding episodes? [No further questions.]	Yes	No
9	What is the indication or diagnosis? [] Cyclic heavy menstrual bleeding (If checked, no further questions) [] Hemophilia (If checked, no further questions) [] All other indications/diagnosis (If checked, no further questions)		

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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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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