maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

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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 the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
2	What is the indication or diagnosis? [] Chorea associated with Huntington's disease (If checked, go to 3) [] Tardive dyskinesia (If checked, go to 8) [] Other (if checked, no further questions)		
3	Is this medication being prescribed by, or in consultation with, a neurologist? [If no, no further questions.]	Yes	No
4	Is this request a continuation of therapy?	Yes	No

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

PRV 07.02.25.2

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	[If yes, skip to question 15.]		
5	Has the patient tried at least ONE other agent for at least 3 months? [Note: Examples of other agents include tetrabenazine with dose optimization, amantadine, and riluzole.] [If yes, skip to question 7.]	Yes	No
6	Does the patient have a documented intolerance to at least TWO other agents? [Note: Examples of other agents include tetrabenazine with dose optimization, amantadine, and riluzole.] [If no, no further questions.]	Yes	No
7	Is the patient's diagnosis confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36)? [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
8	Is this medication being prescribed by, or in consultation with, a neurologist or psychiatrist? [If no, no further questions.]	Yes	No
9	Is the request a continuation of therapy? [If yes, skip to question 14.]	Yes	No
10	Has the patient tried at least ONE other agent for at least 3 months OR has a documented intolerance? [Note: Examples of other agents include tetrabenazine with dose optimization.] [If no, no further questions.]	Yes	No
11	Does the patient have persistent symptoms of moderate or severe tardive dyskinesia indicated on the Abnormal Involuntary Movement Scale (AIMS)? [If no, no further questions.]	Yes	No
12	Does the patient have any ONE of the following: A) Untreated psychiatric illness; B) Score of greater than or equal to 11 on the depression subscale of the Hospital Anxiety and Depression Scale (HADS); C) A history of suicidal thoughts or behavior; D) Hepatic impairment; E) Concurrent use of monoamine oxidase inhibitors, reserpine, tetrabenazine, or valbenazine? [If yes, no further questions.]	Yes	No
13	Does the dose of the requested medication exceed FDA approved label dosing for the indication? [No further questions.]	Yes	No
14	Has documentation been provided to show that the patient's symptoms have improved by a decreased Abnormal Involuntary Movement Scale (AIMS) score from baseline? [If no, no further questions.]	Yes	No

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15	Has the patient been established on the requested medication for at least 3 months with a clinically significant response, as determined by the prescriber?	Yes	No

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

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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