PRIOR AUTHORIZATION REQUEST

KITABIS PAK

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 6) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

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

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	[If yes, skip to question 6.]		
4	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 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	Is the requested medication being used as a nasal rinse? [If yes, no further questions.]	Yes	No
7	What is the diagnosis or indication? [] Cystic fibrosis (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
9	Is the requested medication being prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis? [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has *Pseudomonas aeruginosa* in the culture of the airway? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of cultures: sputum culture, oropharyngeal culture, bronchoalveolar lavage culture.] [If no, no further questions.]	Yes	No
11	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 300 mg every 12 hours (do not administer doses less than 6 hours apart); administer in repeated cycles of 28 days on drug followed by 28 days off drug.]	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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