PRIOR AUTHORIZATION REQUEST

MULTAQ

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 an INITIAL or 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

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 6.]	Yes	No
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	What is the diagnosis or indication? [] Paroxysmal or persistent atrial fibrillation with intent of cardioversion to normal sinus rhythm (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
8	Does the patient have a contraindication to the requested medication? [If yes, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had treatment failure with AT LEAST 1 month of therapy with amiodarone, or has an intolerance or contraindication to amiodarone? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the patient currently taking ANY of the following medications: A) a statin at a strength GREATER than 10 mg, B) sirolimus, C) tacrolimus, D) a class I antiarrhythmic (quinidine, procainamide, disopyramide, lidocaine, mexiletine, flecainide, or propafenone), E) a class III antiarrhythmic (dofetilide, sotalol, or ibutilide)? [If yes, no further questions.]	Yes	No
11	Does the provider attest that the patient is NOT in permanent in atrial fibrillation, and the medication will be used to control ventricular rate? [If no, no further questions.]	Yes	No
12	Does the provider attest that the patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization or New York Heart	Yes	No

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	Association (NYHA) Class IV heart failure? [If no, no further questions.]		
13	Is this medication being prescribed by, or in consultation with, a cardiologist? [If no, no further questions.]	Yes	No
14	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? Note: Dosing is 400 mg twice a day.	Yes	No

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

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SECTION B: Physician Signature

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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.

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