Kansas Medical Assistance Program	**Aetna Better Health of KS**	**Sunflower**	**UnitedHealthcare**
PA Phone 800-933-6593	PA Pharmacy Phone 855-221-5656	PA Pharmacy Phone 877-397-9526	PA Pharmacy Phone 800-310-6826
PA Fax 800-913-2229	PA Pharmacy Fax 844-807-8453	PA Pharmacy Fax 833-645-2740	PA Pharmacy Fax 866-940-7328
	PA Medical Phone 855-221-5656	PA Medical Phone 877-644-4623	PA Medical Phone 866-604-3267
	PA Medical Fax 855-225-4102	PA Medical Fax 888-453-4756	PA Medical Fax 866-943-6474

KANSAS MEDICAID UNIVERSAL PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: ☐ **Drug dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug administered in an office or outpatient setting (medical benefit)**

MEMBER INFORMATION

Name:	Medicaid ID:
Date of Birth:	Gender:

PRESCRIBER INFORMATION

Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Advanced Medical Hold Manual Review (AMHMR) criteria: https://www.kdhe.ks.gov/DocumentCenter/View/337/Advanced-Medical-Hold-Manual-Review-PA-Criteria-PDF?bidId=
- AMHMR Drug List: https://www.kdhe.ks.gov/192/List-of-Drugs-Under-Review
- Clinical PA criteria: https://www.kdhe.ks.gov/206/General-Clinical-Prior-Authorization
- KS Preferred Drug List (PDL): https://www.kdhe.ks.gov/DocumentCenter/View/420/Preferred-Drug-List-PDF?bidId=
- Non-Preferred, PA Required PDL criteria: https://www.kdhe.ks.gov/DocumentCenter/View/418/Non-Preferred-PDL-PA-Criteria-PDF
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

SECTION I: MEDICATION REQUESTED

What is the name of the medication being requested?

____

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO

Indication: ____

ICD-10: ____

Patient's weight: __________ ☐ lbs. ☐ kg

PATIENT NAME:		MEDICAID ID:	

SECTION II: ADVANCED MEDICAL HOLD MANUAL REVIEW

1. Does the medication requested currently have AMHMR status?
   AMHMR Drug List: https://www.kdhe.ks.gov/192/List-of-Drugs-Under-Review
   - ☐ YES
   - ☐ NO – Complete all sections of this form

   If YES: Please provide the criteria reference number associated with the requested medication.
   - ☐ 1 – Complete only section III
   - ☐ 2 – Complete only section IV
   - ☐ 3 – Complete both sections III and IV
   - ☐ 4 – Complete only items #4 and #6 in section IV
   - ☐ 5 – Complete only items #4 and #6 in section IV
   - ☐ 6 – Complete only items #4 and #6 in section IV
   - ☐ Package Insert – No additional information required

SECTION III: NON-PREFERRED MEDICATION

1. Is the medication requested a preferred or non-preferred medication on the Kansas Medicaid preferred drug list (PDL)?
   KS Preferred Drug List (PDL): https://www.kdhe.ks.gov/DocumentCenter/View/420/Preferred-Drug-List-PDF?bidId=

   ☐ Preferred ☐ Non-preferred ☐ Not on PDL

   If Preferred or Not on PDL, skip to Section IV.

   If Non-preferred: Please submit clinical rationale for using a Non-preferred medication that is supported by the product labeling and as specified in the Non-preferred PDL PA criteria?
   Non-Preferred, PA Required PDL criteria: https://www.kdhe.ks.gov/DocumentCenter/View/418/Non-Preferred-PDL-PA-Criteria-PDF
   ____
   ____
   ____
   ____

SECTION IV: CLINICAL INFORMATION

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Please indicate any change in dose, strength, or quantity:

     ☐ Increase ☐ Decrease ☐ No change
2. Please document the physician's specialty or consultation with a specialist, if applicable.
   - ☐ Specialty required

     Provider name: _________________________ Specialty: _________________________ Date of Consult: ________________
   - ☐ Not applicable
3. Please list any pertinent lab values and any other relevant clinical data.

LAB/CLINICAL DATA/TESTING/ASSESSMENTS	DATE

PATIENT NAME:		MEDICAID ID:	

SECTION IV: CLINICAL INFORMATION (continued)

4. Please list all medications and non-drug interventions or therapies the patient has previously tried and failed for treatment of this diagnosis.

*Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance) and dates of previous trial.

Medication/Intervention Name	Reason for Discontinuation	Dates of Trial

5. Please list all medications and non-drug interventions or therapies the patient will use in combination with the medication requested for the treatment of this diagnosis.

CONCURRENT THERAPIES	DATE

6. Other clinical rationale or justifications for this request, if any.

____

____

____

____

____

7. **Does the prescriber attest that the patient is not on disallowed combination therapy?** (i.e. concurrent therapy with multiple immunomodulating biologic agents, janus kinase (JAK) inhibitors, CGRP antagonists, direct-acting antivirals (DAAs), or disease-modifying therapies (DMT) are not allowed)

☐ YES ☐ NO ☐ N/A

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

____ ________________________

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.