**Kansas Medical Assistance Program**
PA Phone 800-933-6593
PA Fax 800-913-2229

**Aetna Better Health of KS**
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

**Sunflower**
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 833-645-2740
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

**UnitedHealthcare**
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

# NON-PREFERRED PDL MEDICATION 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.**

| MEMBER INFORMATION | | |
|---|---|---|
| Name: | Medicaid ID: | |
| Date of Birth: | Gender: | |
| **PRESCRIBER INFORMATION** | | |
| Name: | Medicaid ID: | |
| NPI: | Phone: | Fax: |
| Address: | City, State, Zip Code: | |

Complete the following form to request approval of a non-preferred medication on the Kansas Medicaid Preferred Drug List (PDL).
Please note: Medications requiring PA may have to meet clinical and Non-Preferred PA criteria before the claim may be considered for payment.
A list of PDL classes no longer requiring annual PA renewal can be found on the Non-Preferred, PA Required PDL criteria using the link below.

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:

- 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://portal.kmap-state-ks.us/PublicPage/ProviderPricing/NDCSearch?searchBy=NDC
- KS HCPCS lookup tool: https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/HCPCSSearch?searchBy=HCPCS

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

| REQUESTED DRUG NAME & NDC | STRENGTH/FREQUENCY | QUANTITY | DAY SUPPLY |
|---|---|---|---|
| | | | |
| DIAGNOSIS | | ICD-10 CODE | |
| | | | |

## NON-PREFERRED MEDICATION PRIOR AUTHORIZATION

Check the appropriate box and provide the required information for consideration of approval of the requested non-preferred medication.

☐ Does the medication requested also have clinical criteria?
Search for the requested medication here: https://www.kdhe.ks.gov/DocumentCenter/View/362/Clinical-PA-Drug-Index-PDF?bidId=

☐ YES ☐ NO

If YES: Please complete the Non-preferred sections in the appropriate Clinical PA criteria form. This form does not need to be completed.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI.

## NON-PREFERRED MEDICATION PRIOR AUTHORIZATION (CONTINUED)

☐ If there is one preferred agent in the preferred category, has the patient experienced an inadequate response after a trial of the preferred agent at a maximum tolerated dose, or do they have a documented intolerance or contraindication to the preferred agent?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial and date(s) of trial:
Medication Name: ____________________________ Date(s) of trial: _______________________________
List medication intolerance or contraindication (if any):
______________________________________________________________________________________________

☐ If there are two or more agents in the preferred category, has the patient experienced an inadequate response after a trial of two or more of the preferred agents at their maximum tolerated dose, or do they have a documented intolerance or contraindication to two or more preferred agents?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial and date(s) of trial:
- Medication Name: ____________________________ Date(s) of trial: ______________________________
- Medication Name: ____________________________ Date(s) of trial: ______________________________

List medication intolerance or contraindication (if any):
______________________________________________________________________________________________

☐ An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need.
- For formulation requests, please refer to the Non-Preferred PDL PA criteria to ensure specific requirements for oral, non-solid dosage forms, or nebulized formulations are met https://www.kdhe.ks.gov/DocumentCenter/View/418/Non-Preferred-PDL-PA-Criteria-PDF

______________________________________________________________________________________________

## 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.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI.