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Prime THERAPEUTICS

Arkansas Medicaid Physician Administered Drug Program

Medical Prior Authorization Request Form

Fax form to: 1-800-424-7976 **For questions, call: 1-800-424-7895**

Please attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization).

Requestor Name: _____ **Requestor Phone Number:** _____

Prior Authorization Priority: ☐ Standard ☐ Expedited

Prior Authorization Type: ☐ New Request ☐ Change to Existing Approval

If change to existing, please document the prior authorization number: _____

Type of Change: ☐ Date ☐ Dose ☐ Service Line ☐ Performing Provider

Exception to Policy: ☐ Yes ☐ No

Renewal Request: ☐ Yes ☐ No

If renewal, previous dates of therapy: _____ to _____

If renewal, document the previous PA number: _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID: _____ Date of Birth: _____

Weight: _____kg/lbs Height (ft/in): _____ BSA (m^2), if applicable: _____

PROVIDER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber NPI: _____

Billing Provider Name: _____

Billing Provider Medicaid ID (Must be included on claim submitted for service): _____

Billing Provider Street Address: _____

Billing Provider City: _____ State: _____ Zip Code: _____

DRUG/SERVICE LINE INFORMATION

Facility where medication will be administered: _____

Procedure Code (HCPCS): _____

Modifier (Up to 4): _____ _____ _____ _____

Drug Name: _____ Drug Strength: _____

Dosing Frequency: _____ Route of Administration: _____

HCPCS Units per Dose: _____

Total HCPCS Units Requested for PA duration: _____

Start Date: _____ End Date: _____

HCPCS Units Per Dose: _____ Dosing Frequency: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units Per Dose: _____ Dosing Frequency: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units Per Dose: _____ Dosing Frequency: _____

Modifier (Up to 4): _____ _____ _____ _____

HCPCS Units Per Dose: _____ Dosing Frequency: _____

Last Administration Date*: _____

Number of Units Previously Administered*: _____

Note: If modifiers are included in this request they must also be included in the claim submitted for this service.

***The last administration date and number of units previously administered is needed if requesting a change to existing prior authorization.**

DIAGNOSIS AND MEDICAL INFORMATION

1. What are the beneficiary's relevant diagnoses and ICD-10 codes?

   Diagnoses: _____

   ICD-10 codes: _____

2. Has the beneficiary tried any other medications for this condition? ☐ Yes ☐ No
   a. If **Yes**, what was the medication therapy (specify drug name and dosage)?

      _____

   b. What was the duration of therapy? Specify dates: _____ to _____
   c. What was the response, reason for failure, or allergy?

      _____

   d. Does the prescriber attest that the beneficiary adhered to previous therapies and the trial period was sufficient to allow for a positive treatment outcome or that the drug was discontinued due to an adverse event? ☐ Yes ☐ No
   e. Does the prescriber attest that the trial/failure(s) of the preferred medications are documented in the beneficiary's medical record (evidence of such is subject to audit)? ☐ Yes ☐ No

What additional clinical information do you have that is relevant to this request for prior authorization? Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased dose, as well as whether the beneficiary has any contraindications to the Arkansas Medicaid preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information that is related to exigent circumstances or required under state and federal laws.

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that Arkansas Medicaid or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Performing Provider Signature and Credentials: _____ **Date:** _____
(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Retain this documentation in the patient's medical records. Falsification of medical records is liable to the U.S. government for a civil penalty of not less than $5,000 and not more the $10,000, plus 3 times the amount of damages that the government sustains because of the act of that person. [42 U.S.C.A. § 3729(a)].

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents.

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FORM INSTRUCTIONS

- Please fill out all applicable sections on all pages completely and legibly.
- Complete one form per beneficiary.
- Refer to the Arkansas Medicaid Provider Manuals for each HCPCS code, found online at:

  Online Physician manual (Instructions in Section 292.950):
  https://humanservices.arkansas.gov/wp-content/uploads/PHYSICN_II.doc

  Online Hospital manual (Instructions in Section 272.510):
  https://humanservices.arkansas.gov/wp-content/uploads/HOSPITAL_II.doc

DRUG/SERVICE LINE INFORMATION

- **Billing Provider Name:** Enter the name of provider or facility who is billing the claim to collect payment.
- **Billing Provider Medicaid ID:** Enter the 9-digit Arkansas Medicaid ID of the provider or facility who is billing the claim to collect payment.
- **Name of Facility Location**: Enter the specific name of the location where the medication will be administered (e.g. outpatient hospital, medical office, etc.).
- **Prior Authorization Type:** Enter if standard or expedited review.
- **Exception to Policy:** Requests where J-Code is subject to Arkansas Medicaid posted age, diagnosis, quantity, or contract billing rules. This information is documented in the Procedure Code tables on the DHS website at https://humanservices.arkansas.gov.
- **Procedure code:** Enter the appropriate HCPCS code for the procedure/service you are requesting for authorization.
- **Modifier:** Enter any appropriate HCPCS modifier(s) for the procedure/service you are requesting for authorization.
- **Drug Name:** Enter the name of drug being requested.
- **Drug Strength:** Enter the strength of the drug.
- **Dosing Frequency:** Enter how often the drug will be given.
- **Route of Administration:** Enter how the drug will be administered (e.g., intramuscularly, intravenously).
- **HCPCS Units per Dose:** Enter the total number of HCPCS units per dose.
- **Total HCPCS Units Requested:** Enter the total number of procedure/service units for the PA duration.
- **Start Date:** Enter the first date of service (MM/DD/YYYY) for the procedure listed.
- **End Date:** Enter the last date of service (MM/DD/YYYY) for the procedure listed.
- **Last Administration Date:** Enter the last date the dose was given
- **Number of Units Previously Administered:** Enter the total number of units used from the previous authorization