Print Reset

Arkansas Medicaid Prescription Drug Program

Statement of Medical Necessity Prior Authorization Request

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

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary.

Requestor Name: _____ **Title:** _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA #: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Fax: _____

DRUG INFORMATION

Other specific medication forms can be found at https://ar.primetherapeutics.com/forms-documents.

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Quantity: _____

Dosing Frequency: _____

If renewal, please provide treatment start date: _____

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 were the beneficiary's response to therapy and reason for failure or allergy?

   _____

d. Does the prescriber attest that either the beneficiary adhered to previous therapies and the trial period was sufficient to allow for a positive treatment outcome, or the drug was discontinued due to an adverse event?

☐ Yes ☐ No

e. Does the prescriber attest that the trials/failures 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 for the health plan/insurer 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 the Health Plan, insurer, Medical Group, 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.

Prescriber's Signature: _____ **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)].