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 855-201-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Fax 888-453-4756
PA Medical Phone 877-644-4623

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

Kansas Medicaid Universal Pharmacy/Medical Prior Authorization Request

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

Check One: ☐ **Drug dispensed from a pharmacy (Pharmacy Benefit)**
☐ **Drug administered in an office or outpatient setting (Medical Benefit)**

I. Member Information		II. Provider Information		
Member Plan		Prescriber Name & Specialty		
Member Name		Prescriber NPI		
Medicaid ID		Prescriber Address		
Date of Birth		Prescriber Phone/Fax	Phone:	Fax:
Address 1		Pharmacy Name		
Address 2		Pharmacy NPI		
City		Pharmacy Address		
State		Pharmacy Phone/Fax	Phone:	Fax:
Zip		Facility/Physician Name		
Primary Phone		Facility/Physician Address		
Secondary Phone		Facility/Physician Phone/Fax	Phone:	Fax:

III. Prior Authorization – Drug Specific Required Data

A select number of drugs may require Prior Authorization (PA). Drugs requiring PA may have to meet clinical and/or 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:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/Non-Preferred_PA_Criteria_for_PDL_Drugs.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

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

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.

Requested Drug Name & NDC	Strength/Frequency	Quantity	Days Supply
Requested Drug & HCPCS	**Requested Number of Units**	**Expected Length of Therapy**	

REFER TO CLINICAL CRITERIA TO COMPLETE THIS FORM:

☐ New Therapy **OR**

☐ Renewal Therapy – If renewal, please indicate any change in dose, strength, or quantity:

☐ INCREASE ☐ DECREASE ☐ NO CHANGE

☐ Member's diagnosis related to this request:_____

☐ ICD-10 Code:_____DSM-5 Code: _____

☐ Specialist and role currently involved in assessing the member, performing testing/interventions, providing treatment plans, and prescribing medication:

SPECIALIST	ROLE (CONSULTANT, ORDERING, ETC.)

☐ Member's lab values and clinical data related to this request, such as height and weight. Dates MUST be included:

LAB/CLINICAL DATA	DATE

☐ Other testing and/or assessments done related to this request. Dates MUST be included:

TESTING/ASSESSMENTS	DATE

☐ Previous drug(s) taken for this diagnosis and any relevant information relating to previous drug therapy. Dates MUST be included:

PREVIOUS DRUG THERAPY & RELEVANT INFORMATION	DATE

☐ Other concurrent drug therapy related to this diagnosis:

CONCURRENT DRUG THERAPY

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.

☐ Clinical rationale or justification for request (such as allergies, contraindication to, inadequate response to):

RATIONALE/JUSTIFICATION

☐ Other non-drug interventions/therapies tried and any relevant information related to previous therapies. Dates MUST be included:

NON-DRUG INTERVENTIONS or THERAPIES and RELEVANT INFORMATION	DATE

☐ Attestation of required testing/interventions accomplished or attempted to accomplish and corresponding dates:

PROVIDER NAME	TESTING/INTERVENTION	DATE

IV. 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.