



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Prior Authorization for Non-Preferred Thiazolidinediones

Preferred	Non-Preferred, Prior Authorization Required
Actos® (pioglitazone) ACTOplus Met® (pioglitazone/metformin)	ACTOplus Met XR® (pioglitazone/metformin) Avandamet® (rosiglitazone/metformin) Avandia® (rosiglitazone) Duetact® (pioglitazone/glimepiride)

Beneficiary Information

Name: _____
Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____
NPI #: _____ Phone #: _____ Fax #: _____
Requested Drug: _____ NDC: _____

Prescriber Information

Name: _____ Medicaid ID #: _____
NPI #: _____ Phone #: _____ Fax #: _____

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: _____
- 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: _____

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HPE Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**