KAISER PERMANENTE®

Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____
ICD-10 Code(s): _____

What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)

What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)

Are there any supporting labs or test results? (Please specify)

Use of High Risk Medications (HRMs) in the elderly (applies on patients ≥ 65 years ONLY):

"Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Patient requires a greater quantity for the treatment of a larger surface area **[Topical applications only]**
- ❑ Other: _____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-888-791-7255
For urgent or expedited requests please call 1-888-791-7255
This form may be used for non-urgent requests and faxed to 1-844-403-1028.