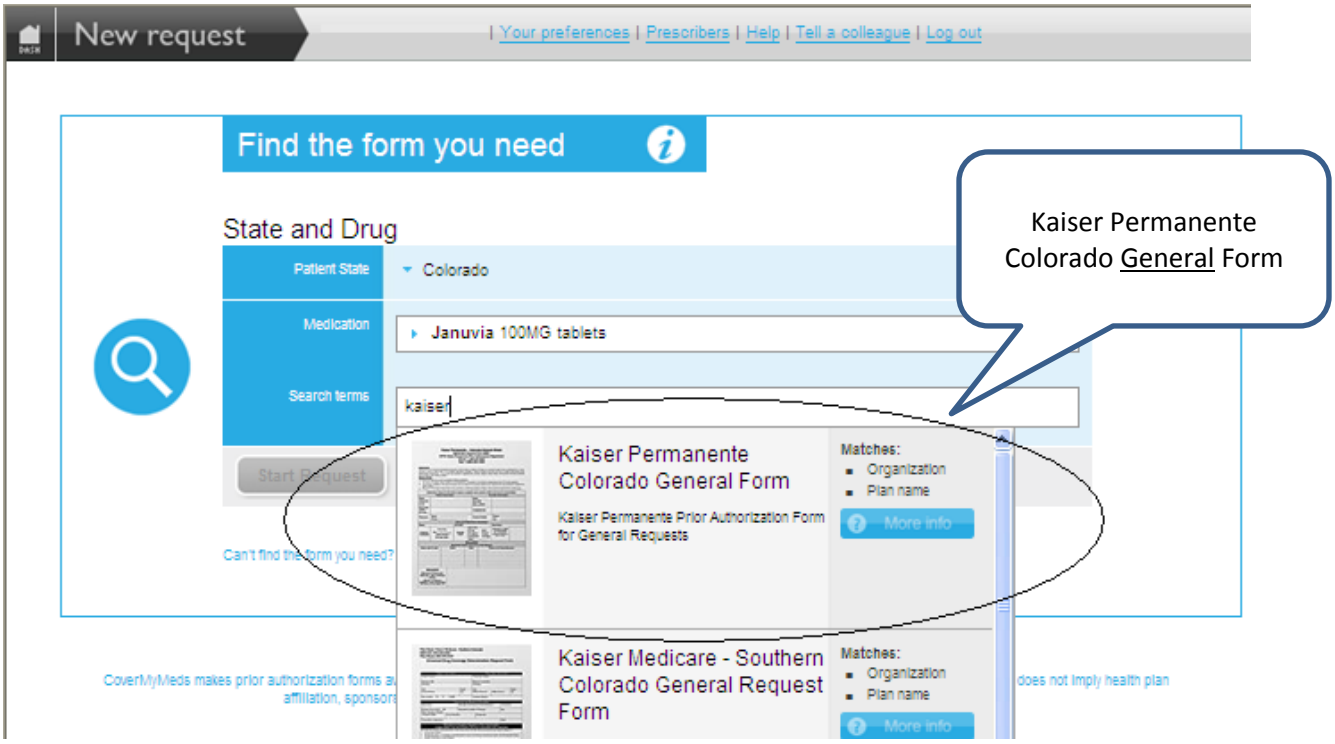
Using *CoverMyMeds* for Kaiser Permanente Members

Dear provider,

If your office uses **CoverMyMeds** to complete medication prior authorization (PA) requests it is important to use the correct form for **Kaiser Permanente** members.

Using the correct form will ensure that your Prior Authorization Requests are sent directly to the Kaiser Permanente Medication Review Team, instead of through a Pharmacy Benefits Manager (PBM).

The following is an example from the **CoverMyMeds** web site and shows the correct form to select for **Kaiser Permanente** members - select **Kaiser Permanente Colorado General Form**:



Please ***do not*** use a form that says MedImpact for your Kaiser Permanente patients. This form will lead to processing delays. Using an incorrect form causes several issues:

- Forms are faxed to incorrect numbers
- Lost forms
- Delay in processing
- HIPAA violations as information is sent to inappropriate people or Health Plans

We are including a copy of the Kaiser Permanente Medication Request Form (MRF). You may manually complete this form, if you do not wish to use *CoverMyMeds*, and fax it to the number listed on the form.

Important: Do not mark requests as urgent unless a standard review will seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Forms are many times incomplete and additional clinical information may be required to make a coverage determination; marking a request as urgent may not allow sufficient time to gather such information and a coverage determination may be issued based on the limited information available.

Kaiser Permanente – Colorado Network Model

Medication Request Form (MRF)

ATTN: Kaiser Permanente Prior Authorization Department

Phone: 1-866-523-0925

Fax: 1-866-455-1053

Instructions:

This form is to be used by participating physicians and providers to obtain coverage for a drug that requires prior authorization or a non-formulary drug for which there is no suitable alternative available. Please complete this form and fax to Kaiser Permanente Prior Authorization Department. If you have any questions regarding this process, please contact Kaiser Permanente Pharmacy Benefits and Compliance at 1-866-523-0925.

Review Criteria:

The following criteria are used in reviewing medical exceptions:

1. The use of Formulary Drug Products is contraindicated in the patient or has failed an appropriate trial of Formulary agent(s).
2. The choices available in the drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
3. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

Medication Request Information (please complete each section of this form prior to transmittal):			
Patient Information		**Provider Information**	
Name		**Name**	
Patient ID		**Specialty**	
D.O.B		**DEA or NPI #**	
Diagnosis (Details) ICD Codes		**Completed By**	
Pharmacy	**Name:** _____ **Phone:** _____	**Contact Details**	**Phone:** _____ **Fax:** _____

Requested Medication Information					
Name:		**Strength:**		**Directions:**	
Ongoing Treatment	(Circle One) **Yes** ___/___/___ (Initial start date) **No, New Start**	**Dosage Form**	(Check One) ❑ Oral ❑ IV ❑ Topical ❑ IUD ❑ Injection ❑ Supp Other:_____	**Intended Length of Treatment** (maximum authorization term is 1 year)	

REQUIRED

Medication History Relevant to this Request

Dates (start & end)	Name	Dose	Reason for Discontinuance

REQUIRED **Statement of Necessity / Rationale / Other Pertinent History** (Allergies, co-diagnosis, disabilities, reasons why formulary alternatives are not suitable, etc.)	