Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
EMVERM CHEW (Mebendazole) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 month

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **EMVERM CHEW (Mebendazole).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber an Infectious Disease Specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Diagnosis of *enterobius vermicularis* (pinworm), **AND**
   □ No □ Yes
2. Patient has had a trial or contraindication to both pyrantel pamoate and albendazole
   □ No □ Yes

--OR--

3. Confirmed diagnosis of *ascaris lumbricoides* (common roundworm), **AND**
   □ No □ Yes
4. Patient has had a trial or contraindication to both pyrantel pamoate and albendazole
   □ No □ Yes

--OR--

5. Confirmed diagnosis of *trichuris trichiura* (whipworm), **AND**
   □ No □ Yes
6. Patient has had a trial or contraindication to albendazole
   □ No □ Yes

--OR--

7. Confirmed diagnosis of *ancylostoma duodenale* (common hookworm), **AND**
   □ No □ Yes
8. Patient has had a trial or contraindication to albendazole
   □ No □ Yes

--OR--

9. Confirmed diagnosis of *necator americanus* (American hookworm), **AND**
   □ No □ Yes
10. Patient has had a trial or contraindication to albendazole
    □ No □ Yes

--OR--

11. Cystic hydatid disease, **AND**
    □ No □ Yes
12. Patient has had treatment failure or contraindication to albendazole
    □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**