

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: <a href="http://www.providers.kaiserpermanente.org/mas/formulary.html">http://www.providers.kaiserpermanente.org/mas/formulary.html</a>

	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	t name and specialty:		
Prescriber Name:	Specialty:	NPI:	
Prescriber Address:			
	Prescriber Fax #:		
3 – Pharmacy Information			
Pharmacy Name:	Pharmacy NPI:		
Pharmacy Phone #	Pharmacy Fax #:		
	4 – Drug Therapy Requested		
Drug 1: Name/Strength/Formulation:			
David 2: Name / Strangth / Formulation			
JIB			

5— Diagnosis/Clinical Criteria			
Initial 1	herapy:		
1.	Diagnosis of enterobius vermicularis (pinworm), AND		
	□ No □ Yes		
2.	Patient has had a trial or contraindication to both pyrantel pamoate and albenda	zole	
	□ 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 albenda	zole	
0.0	□ No □ Yes		
OR	Confirmed diaments of trick with this trick in the control AND		
5.	Confirmed diagnosis of <i>trichuris trichiura</i> (whipworm), <b>AND</b>		
6	Patient has had a trial or contraindication to albendazole		
0.	□ No □ Yes		
OR			
	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 <i>necator americanus</i> (American hookworm), <b>AND</b> □ 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:			
riovide 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.			
Prescri	ber Signature:	Date:	

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