Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 855-201-7170
PA Pharmacy Fax 800-601-4829
PA Medical Fax 855-363-0728
PA Medical Phone 855-201-7170

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Fax 888-453-4756
PA Medical Phone 877-644-4623

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Fax 866-943-6474
PA Medical Phone 866-604-3267

Kansas Medicaid Universal Pharmacy/Medical Prior Authorization Request

Complete form in its entirety and fax to member's plan PA helpdesk
For questions please call the member's plan PA Helpdesk

Please Complete: ☐ **Drug will be dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug will dispensed from provider office, hospital, outpatient stock (Buy and Bill/medical benefit)**

I. Patient Information		II. Provider Information	
Patient Name:		Prescriber Name	
ID Number:		Prescriber Specialty	
Date of Birth:		Prescriber Address	
Address:		Prescriber Phone	
City, State, Zip:		Prescriber NPI	
Primary Phone:		Pharmacy Name	
		Pharmacy Address	
		Pharmacy Phone:	
		Facility/Physician Name	
		Facility/Physician Address	
		Facility/Physician Phone	

III. Prior Authorization – Drug Specific Required Data

A select number of drugs may require Prior Authorization (PA). Drugs requiring PA may have to meet clinical and/or Non-Preferred PDL PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria :http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/Non-Preferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp

Note: Any area not filled out are considered not applicable to your patient & may affect the outcome of this request:

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI

Requested Drug Name & NDC	Strength/Frequency	Quantity	Day Supply
Requested Drug & HCPCS	# Units requested	Expected Length of Therapy	

☐ New Therapy or

☐ Renewal Therapy – If renewal, please indicate any change in dose, strength, or quantity

☐ INCREASED ☐ DECREASED ☐ REMAINED THE SAME

☐ Member's diagnosis related to this request
____

☐ ICD 10 code____

☐ Member's lab values and clinical data related to this request (MUST INCLUDE DATES FOR ALL DATA PROVIDED)
____
____
____
____

☐ Drugs member has taken for this diagnosis and any relevant information relating to therapy
____
____
____

☐ Clinical rationale or justification for request
____
____
____
____

IV. Physician signature

______________________________________ ______________________________

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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