Kansas City

Complete form in its entirety and fax to 816-995-1597, attention PA pharmacist. Contact ACA Medical Management Department at 1-(866)-508-7140 if you have questions.

MEDICAL DRUG PRIOR AUTHORIZATION REQUEST FORM

Request type:

☐ Standard Review (72 hour)

☐ Expedited Review (24 hours) – By checking this box I certify that applying the 72 hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

NOTE: Please complete all fields in the form. Missing information and lack of prompt response to requests for additional information may delay response time. Please attach relevant supporting documentation such as labs, results of diagnostic tests, and office visit notes to this request.

PATIENT INFORMATION

Patient name			DOB	
Street address, city, state, zip				
Blue Medicare Advantage member ID#	Sex M F	Weight	Height	BMI
Drug allergies				

PRESCRIBER INFORMATION

Prescriber name	Provider NPI
Street address, city, state, zip	Provider Specialty
Office phone Office fax	Office contact person and direct extension

DRUG DISPENSING AND ADMINISTRATION INFORMATION

Who is furnishing the drug?

☐ Physician's office or facility will furnish drug

☐ Member picking drug up at a pharmacy.

IMPORTANT NOTE: If member is picking drug up at pharmacy, this request must be faxed to the pharmacy drug prior authorization department at 1-844-403-1029.

Facility where drug is to be administered

☐ Physician's office

☐ Outpatient infusion center

Center name: _____

☐ Home Infusion

Agency name: _____

☐ Self-inject

MEDICATION	
Name of requested medication, dose, route, frequency	
☐ New start ☐ Continued treatment	Next treatment date

DIAGNOSIS AND CLINICAL INFORMATION PLEASE DOCUMENT ICD-10 HERE:
Please provide the diagnosis:
Please include an explanation for the request below. **IN ADDITION, PLEASE ATTACH ANY RELEVANT SUPPORTING DOCUMENTATION SUCH AS LABS, RESULTS OF DIAGNOSTIC TESTS, AND OFFICE VISIT NOTES TO THIS FORM.**

Prescriber signature_____Date_____