Alaska Medicaid

Cost Exceeds Maximum Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: ______________

REQUESTOR INFORMATION

Requestor Name: ______________________________ Title: ______________________

MEMBER INFORMATION

Last Name: __________________________ First Name: ___________________________

Member ID #: ________________________ Date of Birth: ________________________

Sex: ☐ Male ☐ Female Member Phone: _______________________

PRESCRIBER INFORMATION

Last Name: __________________________ First Name: ___________________________

Prescriber NPI: ______________________ Specialty: ____________________________

Prescriber Phone: _____________________ Prescriber Fax: ________________________

PHARMACY INFORMATION

Pharmacy Name: _________________________ Pharmacy NPI: ____________________

Pharmacy Phone: _____________________ Pharmacy Fax: ________________________

DRUG INFORMATION

Drug Name: _____________________________________ NDC: ____________________

Drug Strength: _______________________ Dosage Form: _________________________

Dosage Schedule: _____________________ Quantity: _______ Day Supply: _________

Is this a physician-administered drug? ☐ Yes ☐ No

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Last Name ______________________________ First Name: ____________________________

CLINICAL INFORMATION

1. Diagnosis with ICD-10 code: ____
2. Previous medications/treatments (please include dates and outcomes):

3. Medical justification (attach additional documentation needed to support request):

4. Therapy Type: ☐ New Therapy ☐ Renewal or Continuation of Therapy
   a. For **Continuing Therapy**, indicate disease response:
      ☐ Stabilization of disease ☐ Decrease in disease progression
      ☐ Decrease in symptoms ☐ Other: _______________________________________
5. Is the member experiencing any unacceptable toxicity from the drug for renewal?
   ☐ Yes ☐ No *If YES, describe:* ____

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: ____________________________________ **Date:** ________________

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: (800) 331-4475

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