Alaska Medicaid Atypical Therapeutic Duplication, Exceeds Maximum Quantity Limits, or Child Younger than 5 Years Old 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: __________________________

CLINICAL INFORMATION

Primary diagnosis: ____

Other diagnosis: ____

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Last Name: ________________________________ First Name: ________________________________

DRUG INFORMATION

Drug #1 Name: ________________________________ NDC: ____________________

Drug #1 Strength: ____________________ Dosage Form: ____________________

Dosage Schedule: ____________________ Quantity: __________ Day Supply: __________

Drug #2 Name: ________________________________ NDC: ____________________

Drug #2 Strength: ____________________ Dosage Form: ____________________

Dosage Schedule: ____________________ Quantity: __________ Day Supply: __________

PROVIDE THE FOLLOWING DOCUMENTATION

Therapeutic Duplication:

- Documentation of the condition being treated and that the addition of a second atypical antipsychotic is medically necessary; AND
- Documentation that the initial atypical antipsychotic cannot be discontinued with the addition of the second atypical antipsychotic; AND
- A treatment plan that includes monitoring for adverse drug reactions, metabolic side effects, and efficacy; AND
- Medication profile history showing at least 2 weeks of single-drug therapy at an adequate dose of the medication and progress notes.

Exceeds Maximum Quantity Limits:

- Documentation of the condition being treated and rationale that dosing above maximum limits is medically necessary; AND
- A treatment plan that includes monitoring for adverse drug reactions, metabolic side effects, and efficacy; AND
- Medication profile history showing at least 2 weeks of dosing of medication within limits and progress notes.

Child Younger Than 5 Years of Age:

- A treatment plan that includes monitoring for adverse drug reactions, metabolic side effects, and efficacy **(this is required)**.

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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