Kaiser Permanente of Colorado (KPCO) HMO Medication Prior Authorization Form – Instructions/Process

When an outpatient prescription drug requiring Prior Authorization has been prescribed, please follow the instructions below to request coverage:

1) Please visit www.kp.org/formulary to locate the drug formulary for your benefit. The drug formulary is list of drugs, by disease state, that are included for coverage, with designations for any limitations or prior authorization requirements.
2) Your Prescribing Provider must complete and submit to KPCO Pharmacy Authorization Service the completed KPCO HMO Medication Prior Authorization Form, which is available online at KPCO HMO Medication Prior Authorization Form . You or Your Prescribing Provider may also request a copy of the KPCO HMO Medication Prior Authorization Form from KPCO by calling 1-866-523-0925 or 711 (TTY), 24 hours a day, 7 days a week.
3) KPCO's HMO Medication Prior Authorization Form can be sent to KPCO:
    - via fax at 1-858-357-2615
    - via mail to the following address:

      KPCO Pharmacy Authorization Service
      16601 East Centretech Parkway
      Aurora, CO 80011
4) Once the request has been reviewed and a decision has been made both the Prescribing Provider and the member will be notified of the decision via written letter and if appropriate via telephone
5) Helpful Definitions:
    - Prior Authorization: certain covered outpatient prescription drugs will require an approval where the prescribed medication will be reviewed by KPCO to determine medical necessity before the prescription is filled under the benefit. This review and approval process is called the prior authorization process or the medication exception process.
    - Urgent Prior Authorization Request: A request for prior authorization when based on the reasonable opinion of the Prescribing Provider with knowledge of the Covered Person's medical condition, the time frames allowed for non-urgent prior authorization could: a) seriously jeopardize the life or health of the covered person or the ability to regain maximum function or b) subject the covered person to severe pain that cannot be adequately managed with the drug benefit that is the subject of request for prior authorization.
    - KPCO HMO Medication Prior Authorization Form: the prescription drug prior authorization form used for requesting coverage for outpatient prescription drugs under the HMO line of business.
    - Prescribing Provider: a provider licensed and authorized to write a prescription pursuant to applicable state law to treat a medical condition of a KPCO covered person.

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APPENDIX A

Kaiser Permanente of Colorado - HMO

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:

[**Kaiser Permanente Colorado: Fax 858-357-2615** Phone: 866-523-0925 Address: 16601 East Centretech Pkwy, Aurora, CO 80011

As of January 1, 2020, no prior authorization requirements may be imposed by a carrier for any FDA-approved prescription medication on its formulary which is approved to treat substance use disorders.

☐ **Urgent** [1]	☐ **Non-Urgent**		
Requested Drug Name:			
Is this drug intended to treat opioid dependence?		**Yes** ☐	**No** ☐
If **Yes,** is this a first request within a 12-month period for prior authorization for this drug? *** If Yes, prior authorization is not required for a 5-day supply of any FDA-approved drug for the treatment of opioid dependence and there is no need to complete this form.** *** If No, as of January 1, 2020, a prior authorization is not required for prescription medications on the carrier's formulary and there is no need to complete this form.**		**Yes *** ☐	**No *** ☐

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request ☐ Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of Named Drug(s):	
Start Date and Length of Therapy:	
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]	
For use in clinical trial? (If yes, provide trial name and registration number):	
Drug Name (Brand Name and Scientific Name)/Strength:	

Dose:	Route:		Frequency:
Quantity:	Number of Refills:		
Product will be delivered to:	☐ Patient's Home	☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			

☐ **Approved**	☐ **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:	

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.