



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Epinephrine for Anaphylaxis Auvi-Q Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 1 year ; Continuation- 1 year

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Epinephrine for Anaphylaxis Auvi-Q**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete.** The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Provider Information**

Provider Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Please check the boxes that apply:

Initial Request  Continuation of Therapy Request

Standard Review (72 hours)

Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

Provider Signature \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

### 5 – Diagnosis

Diagnosis/Indication for use: \_\_\_\_\_

### 6 – Clinical Criteria

Check all that apply:

- Yes  No The patient or patient's caregiver is unable to utilize an alternative epinephrine auto-injector device despite documented face-to-face training with a healthcare professional **AND**
- Yes  No The patient or the patient's caregiver has significant functional impairment requiring the need for an auto-injector with audio cues for self-administration

### 7 – Provider Sign-Off

**Additional Information – Please provide any additional information that should be taken into consideration.**

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Provider Signature:**

**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility