Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Movement Disorder Agents 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 **Movement Disorder Agents.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.

KP-MAS Formulary can be found at: https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/pharmacy#formulary

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the Movement Disorder Agent prescribed by or in consultation with a neurologist or psychiatrist? □ No □ Yes

If consulted with a specialist, provide specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

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/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, if Yes, Include start date: _____

2. Does the member have on of the following diagnosis?
   a. Tardive Dyskinesia □ No □ Yes
   b. Huntington's disease □ No □ Yes
   c. Other:_____
      _____

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

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

Prescriber Signature:	**Date:**

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