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# 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:** _____

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