Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Multaq (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Multaq (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Multaq (dronedarone)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Is Multaq being prescribed by or in consultation with a cardiologist? Y N

   [If no, then no further questions.]

2. Does the patient have paroxysmal or persistent atrial fibrillation? Y N

   [If no, then no further questions.]

3. Is the patient currently in normal sinus rhythm OR is it planned to cardiovert the patient to achieve normal sinus rhythm? Y N

   [If no, then no further questions.]

4. Has the patient experienced an inadequate treatment response, intolerable side effects, or contraindication to amiodarone, propafenone, flecainide, or sotalol? Y N

   [If no, then no further questions.]

5. Does the patient have symptomatic heart failure with recent decompensation requiring hospitalization or NYHA Class IV heart failure? Y N

   [If yes, then no further questions.]

6. Does the patient have any contraindications to Multaq? Y N

   [If yes, then no further questions.]

7. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**