

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit,
550 High St., Suite 1000, Jackson, MS 39201



Medicaid Fee for Service/Change Healthcare
Fax to: 1-877-537-0720 Ph: 1-877-537-0722
<https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/>

Magnolia Health/Envolve Pharmacy Solutions
Fax to: 1-866-399-0929 Ph: 1-866-399-0928
<https://www.magnoliahealthplan.com/providers/pharmacy.html>

UnitedHealthcare/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
<http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html>

BENEFICIARY INFORMATION	
Beneficiary ID: _____ - _____ - _____	DOB: _____ / _____ / _____
Beneficiary Full Name: _____	
PRESCRIBER INFORMATION	
Prescriber's NPI: _____	
Prescriber's Full Name: _____	Phone: _____
Prescriber's Address: _____	FAX: _____
PHARMACY INFORMATION	
Pharmacy NPI: _____	
Pharmacy Name: _____	
Pharmacy Phone: _____	Pharmacy FAX: _____
CLINICAL INFORMATION	
Requested PA Start Date: _____ Requested PA End Date: _____	
Drug/Product Requested: _____ Strength: _____ Quantity: _____	
Days Supply: _____ RX Refills: _____ Diagnosis or ICD-10 Code(s): _____	
<input type="checkbox"/> Hospital Discharge	<input type="checkbox"/> Additional Medical Justification Attached
Medications received through coupons and/or samples are not acceptable as justification	
PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW	
<i>Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)</i>	
I certify that all information provided is accurate and appropriately documented in the patient's medical chart.	
Signature required: _____	Date: _____
Printed Name of Prescribing Provider: _____	

FAX THIS PAGE

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-877-537-0722) or fax (1-877-537-0720) and destroy all copies of the original message. 05/05/2017

PRIOR AUTHORIZATION INFORMATION

Brand-Name Multi-Source Drug / Dispense As Written (DAW)

The following brand name drugs are excluded from this requirement:

- *DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.*
- *Preferred branded drugs on DOM's PDL.*

The completed FDA MedWatch form must be included with this request. A copy of the FDA MedWatch form may be obtained online at:

<http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf>

Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries

The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to the age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. See MS Administrative Code, Title 23, Part 223.

Reasons for prior authorization request may include, but are not limited to:

Request for more than 5 prescription claims per month

Request for more than 2 non-preferred/brand name prescription claims per month

Request for a non-preferred drug

Request for a non-covered drug

CRITERIA/ADDITIONAL DOCUMENTATION

BRAND NAME MULTI-SOURCE DRUG



BENEFICIARY INFORMATION

Beneficiary ID: _____ - _____ - _____ DOB: ____/____/____

Beneficiary Full Name: _____

Brand Name Multi-Source Drug / Dispense As Written (DAW) Criteria

MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval

The following brand name drugs are excluded from this requirement:

- DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.
- Preferred branded drugs on DOM's PDL.

The completed FDA MedWatch form must be included with this request. A copy of the FDA MedWatch form may be obtained online at: <http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf>

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product: _____ Manufacturer: _____ Length of Therapy: _____

Observed adverse reaction or allergic reaction: _____

Documentation Included: Yes No

Generic Product: _____ Manufacturer: _____ Length of Therapy: _____

Observed adverse reaction or allergic reaction: _____

Documentation Included: Yes No

Has a completed FDA MedWatch form been submitted to the FDA? Yes No

Printed Name of Prescribing Provider: _____ Date: _____

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