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):_____

☐ **Hospital Discharge** ☐ **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

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

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.
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PRIOR AUTHORIZATION DESCRIPTION

MAXIMUM UNIT OVERRIDE

- In accordance with state law, Medicaid provides up to a 31-day supply of medications.
- The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose.
- Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/
- Medicaid may request chart documentation for verification of submitted information.

Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:
• The request must be substantiated by diagnosis and supporting medical justification.
• Supporting documentation must be available in the patient record.
• Medication will not be approved for non-FDA approved indications.

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CRITERIA/ADDITIONAL DOCUMENTATION
MAXIMUM UNIT OVERRIDE

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION	
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Beneficiary Full Name:	

Maximum Unit Override Request

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1. Specific diagnosis and ICD-10 code(s):
   _____
2. If dosing is weight-based or body surface area-based:

   Beneficiary's Weight: _____ Beneficiary's Height: _____
3. Detailed description of reason beneficiary needs a greater quantity allowed than quantity limit or dose greater than what the FDA approved label recommends:

_____

_____

_____

Printed Name of Prescribing Provider:_____ **Date:**_____

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