

# 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: 1-866-399-0928** Ph: 1-800-460-8988

<https://www.magnoliahealthplan.com/providers/pharmacy.html>

UnitedHealthcare/OptumRx

**Fax to: 1-866-940-7328** Ph: 1-800-310-6826

<http://www.uhcommunityplan.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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