MISSISSIPPI DIVISION OF MEDICAID

PHARMACY PRIOR AUTHORIZATION FORM

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

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | | |

Beneficiary Full Name: _____ **DOB:** _____

Prescriber NPI: | | | | | | | | | | |

Prescriber's Full Name: _____ **Phone:** _____

Prescriber's Address: _____ **FAX:** _____

Pharmacy NPI: | | | | | | | | | | |

Pharmacy Name: _____
Phone: _____ **FAX:** _____

CLINICAL INFORMATION

PA Start Date_____ **End Date**_____

Drug Requested _____ **Strength**_____ **Quantity**_____

Days Supply_____ **RX Refills**_____ **Diagnosis or ICD-9 Code**_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification.

DRUG SPECIFIC INFORMATION

☐ Brand Name Multi Source (Must include MedWatch page and Brand Name Multi Source Page 2 from instructions)
☐ Early Refill (Must include Early Refill Page 2 from instructions)
☐ Enteral Nutrition (Must include Enteral Page 2 from instructions)
☐ Max Unit Override (Must include Max Override Page 2 from instructions)
☐ Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries (Must include Children's Page 2 from instructions)
☐ Preferred Drug List Exception Request (Must include Preferred Drug List Exception Page 2 from instructions)
☐ Solvaldi Initial Therapy (Months 1–2) or Solvaldi Ongoing Therapy (Must include Sovaldi Initial or Ongoing Therapy Page 2 from instructions)
☐ Synagis (Must include Synagis Page 2 from instructions)

☐ Appeal/Reconsideration (Must include Appeal/Reconsider information page 2 from Instructions)

MUST SUBMIT PAGE TWO

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

Signature required: _____ **Date:** _____

Printed name of prescribing provider: _____

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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As of January 1, 2014 and in order for DOM to be in compliance with state law, submissions on forms used previously can no longer be accepted for Medicaid beneficiaries and will be returned to the prescriber.

PA Determination

If the Pharmacy PA unit approves the prior authorization, the beneficiary can return to their pharmacy to obtain the prescription. The drug claim will pay and no further action will be required.

If the Pharmacy PA denies the request, the prescriber's office will be notified immediately. The prescriber has the option of prescribing a different treatment course that does not require prior authorization or submitting the required form.

REMINDER: *Before submitting a PA request, check for options not requiring PA on the current PDL found at http://www.medicaid.ms.gov/Pharmacy.aspx. Medicaid providers are encouraged to use equally efficacious and cost saving* ***preferred*** *agents whenever possible.*

NOTICE: Instructions for successfully completing a Prior Authorization Form

Prior Authorization Page 1 along with ONE of the pages below must be completed and faxed in for prior authorization.

Drug Specific Information:

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 7/01/2014

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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Brand-Name Multi-Source Drug / Dispense As Written (DAW)* Form 2A

PRIOR AUTHORIZATION REQUEST FORM

**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:

_____

_____

_____

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 FDA: ☐Yes ☐No?

PAGE 2.A

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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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Early Refill Pharmacy Prior Authorization Form* Form 2B

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

- *No early refill can be authorized if the beneficiary's monthly service limit has been reached.*
- *MS Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.*
- *MS Medicaid does not pay for vacation supplies.*
- *Current policy requires at least:*
  - *75% of a non-controlled substance prescription claim's day's supply to transpire to pay or a PA request to be approved; or*
  - *85 % of a controlled substance prescription claim's day's supply to transpire to pay or a PA request to be approved.*

Reason for Request:

☐Prescriber increased the dosing frequency
☐Prescriber increased the number of units per dose
☐New Admission to Nursing Home
☐Extra medication needed to stop or mitigate further morbidity due to acute clinical Condition.
Explanation: _____
☐Lost or Stolen: Documentation required**
☐Destroyed (fire, natural disaster, such as flood tornado, hurricane): Documentation required**
☐Other, ***Specify***: _____

Additional Comments:

_____

_____

*The pharmacist should maintain documentation for each early refill override that is obtained from **DOM**.
** Documentation must be provided for prescriptions for controlled substances and/or medication with a potential for abuse or resale. Examples of documentation include a police report, insurance report, etc.
***Supporting documentation must be available in the patient record

PAGE 2.B

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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

NON-PREFERRED ENTERAL NUTRITION Pharmacy Prior Authorization Form Form 2C

- *A copy of the original prescription or order must accompany this PA request.*
- *Enteral nutritional replacements are included in the facilities' per diem rate for residents in a long-term care facility (defined as nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or psychiatric residential treatment facility (PRTF)) and are not reimbursable separately as a pharmacy point of sale service.*
- *Is the beneficiary Medicare eligible?*
  - *Medicare Part B must be billed if the beneficiary is a dually-eligible*
- *Is beneficiary > 21 years of age? YES ☐ NO ☐*
- *Is nutritional requested the sole source of nutrition? YES ☐ NO ☐*
- *EPSDT eligible beneficiaries under 5 years of age, pregnant and postpartum women must register with the federal program for women, infants, and children (WIC).*
  - *If WIC does not provide the desired product, Medicaid may authorize its use.*
  - *If WIC cannot supply all of the beneficiary's needs, Medicaid may authorize additional products. A copy of the completed WIC statement must be attached to this form.*
  - *Is beneficiary WIC eligible? YES ☐ NO ☐*
    - *If YES, indicate the monthly quantity supplied by WIC: _____*

Body Weight: _____kg or _____lb. Height: _____ft. ____in. Date Measured _____

ENTERAL/CLINICAL INFORMATION

Enteral Name and Strength: _____ Quantity /Month: _____

Daily dose: _____ Length of Therapy _____

Medical reason supplement is needed: _____

_____

NDC # _____

Does beneficiary have an inborn error of metabolism? YES ☐ NO ☐

Consultation with a Registered Dietician? YES ☐ NO ☐

Date: _____ Name: _____

Calories prescribed initially verified by _____Ph:_____Fax:_____

Beneficiary ID#: Beneficiary Full Name: _____

PAGE 2.C

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Pharmacy Prior Authorization Unit
550 High St., Suite 1000, Jackson, MS 39201

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | **Beneficiary Full Name:** _____

MAXIMUM UNIT OVERRIDE Pharmacy Prior Authorization Form 2D

- *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/Pharmacy.aspx.*
- *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.

1. Specific diagnosis: _____

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 great than FDA recommends:

_____

_____

_____

PAGE 2.D

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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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries Form 2E

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 non-preferred medication
☐ Request for a non-covered drug

*Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at http://www.medicaid.ms.gov/Pharmacy.aspx . Medicaid providers are encouraged to use equally efficacious and cost saving **preferred** agents whenever possible.*

Requested Medication (Include strength and dosage formulation)	Diagnosis	Preferred Product (Yes/No)	Requested Quantity Per Month
1			
2			
3			
4			
5			

Additional Medical Justification, including age waiver, if applicable:

_____

_____

_____

_____

PAGE 2.E

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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FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Preferred Drug List Exception Pharmacy Prior Authorization Form Form 2F

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at http://www.medicaid.ms.gov/Pharmacy.aspx. Medicaid providers are encouraged to use equally efficacious and cost saving preferred agents whenever possible.

1. Has the patient experienced treatment failure with the preferred products(s)? ☐Yes ☐No

1st Drug _____ Length of Therapy_____

Reason for D/C_____

2ndDrug_____ Length of Therapy_____

Reason for D/C_____

Attach additional documentation of other treatment failures with preferred drugs if necessary.
If no previous preferred drug usage, then additional medical justification must be provided.

2. Does the patient have a condition that prevents the use of the preferred products(s)? ☐Yes ☐No

*If YES, list the interaction(s):*_____

_____

3. Is there a potential drug interaction between another medication and the preferred products(s)?

☐Yes ☐No *If YES, list the interaction(s)*:_____

_____

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ☐Yes ☐No

If YES, list the side effects: _____

_____

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

PAGE 2.F

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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FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary | | | | | | | | | | **ID#: Beneficiary Full Name:** _____

Sovaldi® INITIAL THERAPY PA Request

Form 2G Section 1

MS Division of Medicaid will approve Sovaldi® PA requests for members who meet the following guidelines. This is the INITIAL PA form and will cover the first two 14 day fills and a subsequent 28 day fill. The first and second pages list the various regimens and the clinical situations for which they will be considered medically necessary according to Division of Medicaid criteria, as well as the required supporting documentation. The INITIAL PA must be approved prior to the 1st dose. The ONGOING THERAPY PA FORM must be completed before the 3rd month of therapy starts.

☐**Genotype 1**
❑ Treatment naïve/relapsed (regardless of HIV co-infection)→ **Regimen 1**
❑ Prior null or partial response (w/ or w/out a protease inhibitor) → **Regimen 2**
❑ IFN intolerant*, AND ○ Child-Pugh < 6 → **Regimen 5**
❑ IFN-Intolerant* AND ○ Child-Pugh ≥6 → **Regimen 6**
❑ HIV+, prior null or partial response to PEG/RBV PLUS a protease inhibitor → **Regimen 2**
❑ HIV+, AND prior PEG/RBV non-response → **Regimen 5**
❑ Re-infection of allograft liver after transplant →**Regimen 6**
☐**Genotype 2**
❑ Treatment naïve or relapsed, or null responders w/OUT cirrhosis → **Regimen 3**
❑ Treatment experienced w/ prior null or partial response WITH cirrhosis → **Regimen 1**
❑ Treatment naïve or relapsed, or null responders WITH cirrhosis, AND ○ IFN-Intolerant* → **Regimen 4**
❑ Re-infection of allograft liver after transplant → **Regimen 6**
☐**Genotype 3**
❑ Regardless of prior treatment → **Regimen 1**
❑ IFN-Intolerant* → **Regimen 6**
❑ Re-infection of allograft liver after transplant → **Regimen 6**
☐**Genotype 4**
❑ Regardless of prior treatment → **Regimen 1**
❑ IFN-Intolerant* → **Regimen 6**
☐**Genotype 5 or 6**
❑ Regardless of prior treatment → **Regimen 1**
☐**Awaiting Liver Transplant**
❑ Patient has diagnosis of hepatocellular carcinoma and is awaiting transplant → **Regimen 7**

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FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | **Beneficiary Full Name:** _____

Sovaldi® INITIAL THERAPY PA Request

Form 2G Section 2

REGIMENS:

1. ☐ Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG/IFN x84 days (12 weeks)
2. ☐ Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG/IFN x84 days (12 weeks), AND
   - An additional 84 days (12 weeks) of PEG/IFN to follow
3. ☐ Sovaldi 400mg daily w/ weight-based RBV x84 days (12 weeks)
4. ☐ Sovaldi 400mg daily w/ weight-based RBV x112 days (16 weeks)
5. ☐ Sovaldi 400mg daily PLUS Olysio 150mg daily w/ or w/out weight-based RBV x84 days (12 weeks)
6. ☐ Sovaldi 400mg daily w/ weight-based RBV x168 days (24 weeks)
   - If being for re-infection of allograft liver: will require documented recommendations from transplant center and use of weekly PEG/IFN if tolerated
7. ☐ Sovaldi 400mg daily w/ weight-based RBV (for up to 48 weeks or until liver transplant)
   - Will require documentation of diagnosis and reauthorization every 28 days

☐ **OTHER:**
Please provide clinical rationale for choosing a regimen that is beyond those found within the current guidelines, or for selecting any of the above regimens for alternate genotypes/patient populations.

Sovaldi 400mg daily w/_____ x _____ days (weeks)_

PAGE 2.G
Section 2

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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Beneficiary | | | | | | | | | | **ID#: Beneficiary Full Name:** _____

Sovaldi® INITIAL THERAPY PA Request

Form 2G Section 3

The following documentation must be submitted with initial request for consideration of approval:

❑ Active HCV infection verified by viral load within the last year	❑ HCV Genotype verified by lab
❑ Prescriber is, or has consulted with, a gastroenterologist, hepatologist, ID specialist or other Hepatitis specialist. Requires consult within the past year with documentation of recommended regimen	❑ Documentation of counseling regarding abstinence from alcohol, IV drug use and education on how to prevent HCV transmission. Documentation of abstinence from drugs and alcohol for at least 6 months; negative urine drug screen required if there is a history of IV drug use.
❑ Patient is not receiving dialysis and has CrCl ≥ 30mL/min ❑ Verified by lab results including a creatinine level within the past 6 months	❑ Current medication list that does NOT include: carbamazepine, phenytoin, Phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort or tipranavir.
❑ **For women of childbearing potential** (and male patients with female partners of childbearing potential): ❑ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of stopping ❑ Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after stopping ❑ Verification that monthly pregnancy tests will be performed throughout treatment	
❑ **For IFN-Intolerant*** (for use with regimens 4, 5, 6 or Other if applicable): ❑ Documented life-threatening side effects or potential side effects (i.e. history of suicidality) ❑ Decompensated cirrhosis (Child-Pugh >6) • Or Child-Pugh ≥ 6 if co-infected with HIV ❑ Blood dyscrasias: • Baseline neutrophil count <1500/µL, baseline platelets <90,000/µL or baseline Hgb <10g/dL ❑ Pre-existing unstable or significant cardiac disease (e.g. history of MI or acute coronary syndrome) ❑ Other: _____	
❑ **FOR REGIMEN 7:** Transplant date: _____ ❑ Not yet scheduled	

Provider Signature: _____ **Date of Submission:** _____

***MUST MATCH PROVIDER LISTED ON PAGE ONE**

PAGE 2.G
Section 3

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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Sovaldi® ONGOING THERAPY PA Request

Form 2G Section 4

Mississippi Division of Medicaid will approve Sovaldi® PA requests for members who meet the following guidelines. The Initial PA must be approved prior to the 1st dose. This ONGOING THERAPY PA FORM must be completed for each month of therapy after first 8 weeks (First 8 weeks are covered on Initial Therapy PA Request).

REGIMEN BEING USED:

1. Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG x84 days (12 weeks) ☐
2. Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG x84 days (12 weeks)
   a. With an additional 84 days (12 weeks) of PEG/RBV to follow ☐
3. Sovaldi 400mg daily w/ weight-based RBV x84 days (12 weeks) ☐
4. Sovaldi 400mg daily w/ weight-based RBV x112 days (16 weeks) ☐
5. Sovaldi 400mg daily PLUS Olysio 150mg daily w/ or w/out weight-based RBV x84 days (12 weeks) ☐
6. Sovaldi 400mg daily w/ weight-based RBV x164 days (24 weeks) ☐
7. Sovaldi 400mg daily w/ weight-based RBV (for up to 48 weeks or until liver transplant) ☐

☐ **OTHER:**
Please provide clinical rationale for choosing a regimen that is beyond those found within the current guidelines, or for selecting any of the above regimens for alternate genotypes/patient populations.

Sovaldi 400mg daily w/_____x_____days (weeks)_

- ❑ **Patient has remained compliant (>85%) on all medications throughout first 2 months of treatment, AND**
- ❑ **Documentation is attached giving evidence of said compliance in the form of:**
  - **Week-4 Viral Load showing a LOG decrease in HCV viral RNA, OR**
  - **Chart notes from an office visit documenting an appropriate compliance discussion, OR**
  - **Other appropriate lab value (with clinical rationale for use):_____**
- ❑ **Patient is a woman of child-bearing potential**
  - **Monthly pregnancy tests have been performed with negative results, AND**
  - **Patient agrees to continue use of two forms of effective non-hormonal contraception**
- ❑ **FOR REGIMEN 7:** Transplant date: _____

  ❑ Not yet scheduled

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ONE PAGE ONE**

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For Information Call:
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Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

Synagis Prior Authorization Form* **Form 2H**

Injections approved starting October 29, 2013 - March 31, 2014 for a maximum of up to 5 injections

PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes approved pharmacy providers from the 2013-2014 seasons. If the approved provider for this request is not included in this list, please select other and provide pharmacy provider information (name, address, telephone number, Medicaid provider number, etc.).

☐ Lincare ☐ MEDFUSION (BriovaRx) ☐ NMMC ☐ UMC ☐ VitalCare

☐ Other NPI: _____ PH: _____ Fax: _____

NDC#:_____Gestational Age: ____ Wks.: _____ Days: ____ Birth Weight: _____lbs. ____oz.

Current Weight: _____lbs. ____oz. Date last weighed: _____

Did the patient receive Synagis in the hospital? Yes ____ No ____ if yes, list date(s) of administration:

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

Risk Factors: Check all that apply.

☐ **Chronic Lung Disease with a diagnosis of BPD requiring medical treatment within the past six months prior to RSV season** (e.g. diuretics, systemic steroids, oxygen on continuous basis, bronchodilators or ventilator dependent). Chronic Lung Disease (CLD) also known as bronchopulmonary dysplasia (BPD): an infant less than 32 weeks' gestation evaluated at 36 weeks' postmenstrual age or an infant of more than 32 weeks' gestation evaluated at more than 28 days but less than 56 days of age who has been receiving supplemental oxygen for more than 28 days. CLD of prematurity of is defined as CLD with gestational age less than 35 weeks. High risk is defined as those who receive treatment for CLD within the previous 6 months prior to RSV season, specifically treatment with corticosteroids, diuretics, bronchodilators or oxygen**. Note*: CLD does not include croup, URI, bronchitis, bronchiolitis, asthma, or wheezing.***

☐ **Hemodynamically Significant Congenital Heart Disease**. **(CHD)**: children with congenital heart disease who are receiving medication to control congestive heart failure, have moderate to severe pulmonary hypertension, or have cyanotic heart disease. Decisions regarding prophylaxis with Synagis in children with CHD should be made on the basis of the degree of the physiologic cardiovascular compromise.

*****Supporting documentation must be submitted with request*****

☐ Severe neuromuscular disease – up to 12 months
☐ Congenital abnormality of the airway – up to 12 months
☐ Is the child in Day Care?
☐ Does the child have siblings who are permanent resident in the home and less than 5 years old?

Mississippi Medicaid is a federally-subsidized health care program funded with public dollars. As such, I confirm that this medication will be administered to the patient for whom it is dispensed. If I or my staff are unable to administer this medication to the designated patient, I acknowledge that I am responsible for notifying the dispensing pharmacy immediately

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.

MISSISSIPPI DIVISION OF MEDICAID

PHARMACY PRIOR AUTHORIZATION FORM

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

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | | **Beneficiary Full Name:** _____

PHARMACY PRIOR AUTHORIZATION APPEAL/ RECONSIDERATION REQUEST FORM Form 2I

- *MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.*
- *Request must be submitted within 30 (thirty) days form the date of the denial notice.*
- *Medicaid beneficiary or prescriber may submit a written request on this form.*
- *Beneficiary and/or prescriber is encouraged to submit additional information which may affect the appeal review determination.*

PA REQUEST INFORMATION:

Date of Request: _____ Requested By: ☐Prescriber ☐Beneficiary

Date of Denial Notification: _____

RATIONALE/MEDICAL REASON FOR RECONSIDERATION

_____

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