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.

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.

7/01/2014
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/providers/pharmacy/preferred-drug-list/](http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/) 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:

- **Brand Name Multi Source**  
  - Page 2.A
- **Early Refill**  
  - Page 2.B
- **Enteral Nutrition**  
  - Page 2.C
- **Max Unit Override**  
  - Page 2.D
- **Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries**  
  - Page 2.E
- **Preferred Drug List Exception Request**  
  - Page 2.F
- **Solvaldi Initial Therapy (Months 1–2) or Solvaldi Ongoing Therapy**  
  - Page 2.G
- **Synagis**  
  - Page 2.H
- **Appeal/Reconsideration**  
  - Page 2.I

---

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. 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.

7/01/2014
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. 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. 7/01/2014
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
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: ____________________________________________

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: ________________________________

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. 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.

7/01/2014
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 greater than FDA recommends:

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
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. 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.

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

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.

<table>
<thead>
<tr>
<th>Requested Medication (Include strength and dosage formulation)</th>
<th>Diagnosis</th>
<th>Preferred Product (Yes/No)</th>
<th>Requested Quantity Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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. 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.

7/01/2014
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
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. 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.

7/01/2014
### Sovaldi® INITIAL THERAPY PA Request

**Form 2G Section 3**

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active HCV infection verified by viral load within the last year</td>
<td>HCV Genotype verified by lab</td>
</tr>
<tr>
<td>Prescriber is, or has consulted with, a gastroenterologist, hepatoologist, ID specialist or other Hepatitis specialist. Requires consult within the past year with documentation of recommended regimen</td>
<td>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.</td>
</tr>
<tr>
<td>Patient is not receiving dialysis and has CrCl ≥ 30mL/min</td>
<td>Current medication list that does NOT include: carbamazepine, phenytoin, Phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John’s Wort or tipranavir.</td>
</tr>
<tr>
<td>For women of childbearing potential (and male patients with female partners of childbearing potential):</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after stopping</td>
<td></td>
</tr>
<tr>
<td>Verification that monthly pregnancy tests will be performed throughout treatment</td>
<td></td>
</tr>
<tr>
<td>For IFN-Intolerant* (for use with regimens 4, 5, 6 or Other if applicable):</td>
<td></td>
</tr>
<tr>
<td>Documented life-threatening side effects or potential side effects (i.e. history of suicidality)</td>
<td></td>
</tr>
<tr>
<td>Decompensated cirrhosis (Child-Pugh &gt;6)</td>
<td></td>
</tr>
<tr>
<td>Or Child-Pugh ≥ 6 if co-infected with HIV</td>
<td></td>
</tr>
<tr>
<td>Blood dyscrasias:</td>
<td></td>
</tr>
<tr>
<td>Baseline neutrophil count &lt;1500/µL, baseline platelets &lt;90,000/µL or baseline Hgb &lt;10g/dL</td>
<td></td>
</tr>
<tr>
<td>Pre-existing unstable or significant cardiac disease (e.g. history of MI or acute coronary syndrome)</td>
<td></td>
</tr>
<tr>
<td>Other: __________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>FOR REGIMEN 7: Transplant date: ____________________</td>
<td></td>
</tr>
<tr>
<td>Not yet scheduled</td>
<td></td>
</tr>
</tbody>
</table>

Provider Signature: __________________________________________________ Date of Submission: ______________

*MUST MATCH PROVIDER LISTED ON PAGE ONE

---

**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. **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.**

7/01/2014
Sovaldi® ONGOING THERAPY PA Request

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:
  o Week-4 Viral Load showing a LOG decrease in HCV viral RNA, OR
  o Chart notes from an office visit documenting an appropriate compliance discussion, OR
  o Other appropriate lab value (with clinical rationale for use):________________________

☐ Patient is a woman of child-bearing potential
  o Monthly pregnancy tests have been performed with negative results, AND
  o 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

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

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. 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.

PAGE 2.G Section 4

7/01/2014
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. 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.

7/01/2014
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. 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.

PAGE 2.I

7/01/2014