



# STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

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

**Magnolia Health/Envolv Pharmacy Solutions**  
Fax to: 1-877-386-4695 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.uhcommunityplan.com/health-professionals/ms/pharmacy-program.html>

**Molina Healthcare/CVS Caremark**  
Fax to: 1-844-312-6371 Ph: 1-844-826-4335  
<http://www.molinahealthcare.com/providers/ms/medicaid/pages/home.aspx>

**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/>

## 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. 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. 07/01/2019

# CRITERIA/ ADDITIONAL DOCUMENTATION EPSDT MEDICAL NECESSITY



## BENEFICIARY INFORMATION

Beneficiary ID: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Beneficiary Full Name: \_\_\_\_\_

## Medical Necessity for EPSDT-eligible beneficiaries Request

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 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 6 prescription claims per month
- Request for more than 2 non-preferred/brand name prescription claims per month
- Request for waiver with provider attestation (see waiver at bottom of form)
- Request for non-covered medication (drug not federally rebated)
- Other: example, drug closed to pharmacy coverage and covered as a medical claim

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

Requested Medication (Include strength and dosage formulation)	Diagnosis	ICD-10 Codes	Preferred Product (Yes/No)	Requested Quantity Per Month
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Medical Necessity: \_\_\_\_\_  
\_\_\_\_\_

**Waiver (if applicable):** I am aware that this drug is not FDA approved or has limitations for use due to:

- the beneficiary's age
- medical condition and/or diagnosis

However, I attest that the medical necessity outweighs the risk for this/these medication(s).

Printed Name of Prescribing Provider: \_\_\_\_\_ Date: \_\_\_\_\_

## FAX THIS PAGE