MISSISSIPPI DIVISION OF MEDICAID

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: 1-877-386-4695 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.uhccommunityplan.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

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:_____

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PRIOR AUTHORIZATION DESCRIPTION

Early Refill

Rule 1.7: Refills/Renewals of Prescription Drugs

A. A written, faxed, e-prescribed, or telephoned prescription may be refilled, in compliance with the prescriber's order, up to a limit of eleven (11) times per year, if compliant with state and/or federal regulations and guidelines. Additionally, the following are applicable:

1. The absence of an indication to refill by the prescribing provider renders the prescription non-refillable.

2. Refills are reimbursable only if specifically authorized by the prescribing provider.

3. Medicaid does not reimburse for prescription refills that exceed the specific number authorized by the prescribing provider.

4. Medicaid does not reimburse for any refills dispensed after one (1) year from the date of the original prescription.

5. Medicaid does not reimburse for a prescription refill with greater frequency than the approximate interval of time that the dosage regimen of the prescription would indicate, unless extenuating circumstances are documented which would justify the shorter interval of time before the refilling of the prescription.

6. Medicaid does not reimburse for quantities in excess of the prescribing provider's authorization.

B. Medicaid does not reimburse for any refill without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each filling event. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

C. Medicaid beneficiaries or providers cannot waive the explicit refill request and enroll beneficiaries in an electronic automatic refill in pharmacies.

D. Medicaid does not reimburse for a prescription refill until seventy five percent (75%) of the day's supply of the drug has elapsed as indicated on the prescription.

1. For any controlled substance (Schedule III, IV, and V), Medicaid does not reimburse for a prescription refill until eighty five percent (85%) of the day's supply of the drug has elapsed as indicated on the prescription. Any attempt to refill a prescription through the Point-of-Sale system before the twenty-sixth (26th) day will be automatically denied.

2. By law, Schedule II narcotics cannot be refilled.

E. As long as the monthly service limits have not been exhausted, Medicaid may permit an early refill of an original claim under one (1) of the following circumstances:

1. The client's life is at risk,

2. When an acute clinical condition is occurring, which would require extra medication to stop or mitigate further morbidity, or

3. The prescribing provider either increases the dosing frequency or increases the number of tablets per dose. The prescribing provider must document the change in dosage or frequency by writing or phoning in a new prescription. The prescriber(s) who wrote the original prescription must initiate any request for additional medication.

F. Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.

1. Replacement of prescriptions is the beneficiary's responsibility.

2. If a beneficiary requires an early refill, the prescribing provider must request an exception override of this requirement by seeking approval from Medicaid's Pharmacy Bureau Prior Authorization (PA) Unit.

Source: Miss. Code Ann. § 43-13-121

CRITERIA/ADDITIONAL DOCUMENTATION
EARLY REFILL

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION	
Beneficiary ID: ____ ____ ____ - ____ ____ ____ - ____ ____ ____	**DOB:____ ____/____ ____/____ ____ ____ ____**
Beneficiary Full Name:	

Early Refill Pharmacy Criteria*

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:**
  - **a) 75% of a non-controlled substance prescription claim's days supply to transpire to pay or a PA request to be approved; or**
  - **b) 85 % of a controlled substance prescription claim's days 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 a 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:_____

_____

_____

_____

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

* 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.

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