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:_____

FAX THIS PAGE

6/21/2019

PRIOR AUTHORIZATION DESCRIPTION

Enteral Nutrition

Enteral nutrition is used as a nutritional replacement for patients who are unable to get enough nutrients in their diet. These formulas are taken by mouth or through a feeding tube and are used by the body for energy and to form substances needed for normal body functions. Documentation to support coverage of enteral nutrition must be maintained in the beneficiary's medical record.

A copy of the original prescription or order must accompany this PA request.

• Enteral nutritional replacement products 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]). Enteral products ARE NOT REIMBURSABLE separately as a pharmacy "point of sale" service.
• If the beneficiary is Medicare eligible, then Medicare Part B or Medicare Advantage must be billed first as primary coverage.

DOM covers enteral nutrition when one of the following criteria is met:

1. For beneficiaries with inborn errors of metabolism.

2. For beneficiaries age 21 years or older, the requested enteral nutritional product must be the sole source of nutrition or when there are special circumstances (such as chemotherapy and/or radiation therapy to the head and neck region, etc.) that justify the need for enteral nutrition.

3. For EPSDT-eligible beneficiaries, specialized enteral feedings must constitute more than 50% of the nutritional needs. A qualifying diagnosis is required.

- EPSDT beneficiaries up to age 5 years must be registered with the federal program for women, infants, and children (WIC) in order to receive WIC monthly nutritionals. If WIC eligible, DOM *may* allow up to a 30 day transition period for NEW starts on WIC covered products.
- Provide an estimate of initial coverage needs until WIC benefits start or if there is a gap in coverage of WIC benefits (up to, but not more than, a 30-day supply).
- Please attach and FAX to 877-537-0720 a copy of the WIC program formula request form when submitting this PA form. Include the WIC Monthly Quantity Limit and the average amount needed after WIC benefits are exhausted.

4. The unique composition of the formula must contain nutrients the beneficiary is unable to obtain from food. The composition of the formula must represent an integral part of the treatment of the specified diagnosis and/or condition.

It must be documented that the beneficiary is either unable to take oral nutrition or unable to sufficiently maintain life without an enteral nutritional replacement product.

Approval may be granted for up to 12 months. A prior authorization for enteral nutrition is for the nutritional product only and *does not* include supplies necessary to administer the nutrient.

CRITERIA/ADDITIONAL DOCUMENTATION
ENTERAL NUTRITION

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION

Beneficiary ID:____ ____ ____ - ____ ____ ____ - ____ ____ ____ | **DOB:**____ ____ /____ ____ /____ ____ ____ ____

Beneficiary Full Name:

Enteral Nutrition Criteria

A copy of the original prescription or order must accompany this PA request.

- **Enteral nutritional replacement products 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]). Enteral products *ARE NOT REIMBURSABLE* separately as a pharmacy "point of sale" service.**
- **If the beneficiary is Medicare eligible, then Medicare Part B or Medicare Advantage must be billed first as primary coverage.**

Enteral Nutrition may be approved for beneficiaries meeting specified criteria:

- **Does the beneficiary have an inborn error of metabolism? YES ☐ NO ☐**
- **If non-EPSDT eligible, is enteral product requested the sole source of nutrition? YES ☐ NO ☐**
- **If EPSDT eligible, is enteral product requested sole source or primary (>50%) source of nutritional needs? YES ☐ NO ☐**
- **Is beneficiary eligible and registered with WIC? YES ☐ NO ☐**
  EPSDT eligible beneficiaries up to age 5 years must be registered with the federal program for women, infants, and children (WIC) in order to receive WIC monthly enteral products.

Enteral/Clinical Information:

Enteral Product Name and Strength: _____ _____NDC Number*: _____
Note: NDC Numbers are needed for processing and can be obtained by contacting enteral product pharmacy providers.

Quantity:_____ per ☐ Month OR ☐ Day

- **Age <5 years, and WIC eligible, please indicate:**
  - **If WIC eligible, DOM *MAY* allow up to a 30 day transition period for NEW starts on WIC covered products.**
  - ***Initial* Coverage *until* WIC Benefits start or a *GAP* in coverage of WIC benefits (up to, but not more than, a 30-day supply): _____ -day supply**
  - ***Please attach and FAX a copy of the WIC program formula request form when submitting this PA form.***
  - **WIC Monthly Quantity Limit:_____**
  - **Average monthly amount needed after WIC benefits are exhausted:_____**

OR

- **Inborn Errors of Metabolism: ☐Yes Diagnosis/ICD-10 code(s):_____ ☐No**

OR

- **Sole Source of Nutrition (solid food not an option-tube feeding) OR special circumstances such as chemotherapy and/or radiation therapy to the head and neck region, etc.): ☐Yes Diagnosis/ICD-10 code(s):_____ ☐No**

OR

- **Primary (>50%) or sole source of nutritional needs if EPSDT eligible: ☐Yes Diagnosis/ICD-10 code(s):_____ ☐No**

Medical Justification:
_____

Printed Name of Prescribing Provider:_____ Date:_____
Approval may be granted for up to 12 months. A prior authorization for enteral nutrition is for the nutritional product only and does not include supplies necessary to administer the nutrient.

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