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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CRITERIA/ADDITIONAL DOCUMENTATION

Multiple Antipsychotics for Patients Less Than Age 18 Years

(Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications)

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION

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

Beneficiary Full Name:

Antipsychotics (Multiple) for Patients Less Than Age 18 Years

Gender: ☐ Male ☐ Female **Age:**_____ **Medication Request:** ☐New ☐Continuation

Beneficiary under State Care/Custody: ☐ Yes ☐ No ☐ Unknown

Diagnosis: *(check all that apply)*

☐ ADHD ☐ Autism Spectrum ☐ Bipolar Disorder ☐ Disruptive Behavior Disorder

☐ Disruptive Mood Dysregulation Disorder ☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Tourette's

Other: _____

Height: _____ in. ***OR*** _____cm. **Weight:** _____ lb. ***OR*** _____kg. **BMI**: _____

Target Symptoms: (check all that apply) ☐ Aggression ☐Impulsivity ☐Irritability

Mood Instability: ☐ Depression ☐Mania ☐ Psychosis ☐ Self-Injurious Behavior ☐ Other: _____

Overall Target Symptoms Severity: ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

Functional Impairment: ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

List All Current Medications:_____

Antipsychotic Requested	Strength	Directions	Quantity

☐ Yes ☐ No ☐ NA If prescribing more than one (1) antipsychotic, is the plan to cross taper, with antipsychotic dual/monotherapy resumed within the next ninety (90) days? (if applicable)

IF YES: Which of the medication(s) listed above will be discontinued?_____

IF NO: What is the rationale for continuing treatment with two (2) or more antipsychotics? _____

☐Yes ☐ No Beneficiary has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies, such as, but not limited to, evidence based behavioral, cognitive, and family based therapies.

☐ Yes ☐ No Beneficiary is currently receiving non-pharmacologic/psychosocial services.

☐ Yes ☐ No For a beneficiary not currently receiving non-pharmacologic/psychosocial services, a referral has been made and an appointment is pending. If there is no pending appointment, provide explanation below:

_____

_____

Has an assessment for Extrapyramidal Symptoms, including Tardive Dyskinesia (TD) been done in the last 26 weeks (6 months)? **AIMS**: ☐Yes ☐No ***OR*** **DISCUS**: ☐Yes ☐No **AIMS/DISCUS Forms**

☐ Yes ☐ No Medical record documentation of metabolic monitoring: weight or BMI, blood pressure, fasting glucose, and a fasting lipid panel within the last 12 months.

Next appointment date: _____

I certify that the benefits of antipsychotic treatment outweigh the risks of treatment.

Prescriber's Signature: _____ **Specialty:** _____

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