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

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.

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6/21/2019

PRIOR AUTHORIZATION DESCRIPTION

MISSISSIPPI DIVISION OF MEDICAID

Preferred Drug List Exception Request

Rule 1.10: Preferred Drug List

A. The Division of Medicaid recommends that prescribers use the drugs on the Preferred Drug List (PDL).

1. The PDL is defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, comprised of a group of prescribers, pharmacists, nurse practitioners, and/or other health care professionals. Final approval of the PDL is the responsibility of the Executive Director of the Division of Medicaid.

2. The PDL contains a wide range of generic and preferred brand name products approved by the FDA.

3. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

B. Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria have been met.

C. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs still in clinical trials and/or investigative or experimental in nature.

D. The PDL is subject to change. Refer to the Division of Medicaid's website for a current listing of prescription drugs on the PDL.

Source: Miss. Code Ann § 43-13-121; Section 127 Social Security Act

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6/21/2019

CRITERIA/ADDITIONAL DOCUMENTATION
PREFERRED DRUG EXCEPTION

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

Preferred Drug List Exception Criteria/Additional Documentation

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.

Prior drugs used must be reflected in paid pharmacy claims.

1. Has the patient experienced treatment failure with the preferred products(s)? .... ☐ YES ☐ NO

1st Drug: ____________________________________ Length of Therapy:__________________________________

Reason for D/C:____

2nd Drug: ____________________________________ Length of Therapy:__________________________________

Reason for D/C:____

Attach additional documentation of other treatment failures with preferred drugs if necessary. If no previous preferred drug usage, then additional medical justification must be provided.

2. Does the patient have a condition that prevents the use of the preferred products(s)?................................. ☐ YES ☐ NO

If YES, list the condition/issue(s): ____

____

3. Is there a potential drug interaction between another medication and the preferred products(s)?............... ☐ YES ☐ NO

If YES, list the interaction(s):____

____

4. Has the patient experienced intolerable side effects while on the preferred product(s)? .... ☐ YES ☐ NO

If YES, list the side effects(s):____

____

Printed Name of Prescribing Provider:____ **Date:**___________________________________

*MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.

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