**STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM**

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

**Beneficiary Information**

|---------------------------------------------------------------|---------------------------------------------|

**Beneficiary Full Name:**

**Prescriber Information**

Prescriber’s NPI: ____________  
Prescriber’s Full Name: ____________  
Prescriber’s Address: ____________  
Phone: ____________  
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**
CRITERIA/ADDITIONAL DOCUMENTATION
UNIVERSAL PRIOR AUTHORIZATION REQUEST

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<th>BENEFICIARY INFORMATION</th>
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<tr>
<td>Beneficiary ID: _______ - _______ - _______ - _______  DOB: _______ / _______ / _______</td>
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<tr>
<td>Beneficiary Full Name:</td>
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Universal Prior Authorization Request

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/. 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. Is the diagnosis for the agent requested a FDA approved indication?
   - [ ] Yes (see # 2)
   - [ ] No (see # 3)

   If no, then please sign the following waiver:

   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

   See waiver signature required at the end of form to attest that the medical necessity outweighs the risk for this/these medication(s).

2. Is there a preferred agent on the PDL used for the treatment for this diagnosis?
   - [ ] Yes (see #3)
   - [ ] No (see #4)

3. Has the patient experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects?

   If Yes, please give a detailed explanation:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

1st Drug: ____________________________  Length of Therapy: ____________________________
2nd Drug: ____________________________  Length of Therapy: ____________________________

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.

4. Please provide the treatment plan for this diagnosis including, but not limited to: pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Printed Name of Prescribing Provider: ____________________________  Date: ____________________________

If applicable, please attest to waiver by checking box and providing your signature below:
- [ ] Waiver: I attest that the medical necessity outweighs the risk for this/these medication(s).

Signature: ____________________________  Date: ____________________________

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