MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, PO Box 2480, Ridgeland, MS 39158

☐ **Medicaid Fee for Service**/Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
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

CRITERIA/ ADDITIONAL DOCUMENTATION
EPSDT MEDICAL NECESSITY

MISSISSIPPI DIVISION OF MEDICAID

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

Medical Necessity for EPSDT-eligible beneficiaries Request

The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. See MS Administrative Code, Title 23, Part 223.

Reasons for prior authorization request may include, but are not limited to:

- ☐ Request for more than 6 prescription claims per month
- ☐ Request for more than 2 non-preferred/brand name prescription claims per month
- ☐ Request for waiver with provider attestation (see waiver at bottom of form)
- ☐ Request for non-covered medication (drug not federally rebated)
- ☐ Other: example, drug closed to pharmacy coverage and covered as a medical claim

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.*

Requested Medication (Include strength and dosage formulation)	Diagnosis	ICD-10 Codes	Preferred Product (Yes/No)	Requested Quantity Per Month
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Medical Necessity: _____

_____

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

However, I attest that the medical necessity outweighs the risk for this/these medication(s).

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

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