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.uhcommunityplan.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**

<table>
<thead>
<tr>
<th>BENEFICIARY INFORMATION</th>
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<td>Beneficiary ID: _____ _____ - _____ _____ - _____ _____</td>
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<td>Beneficiary Full Name:</td>
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**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/](https://medicaid.ms.gov/providers/pharmacy/). Medicaid providers are encouraged to use equally efficacious and cost saving preferred agents whenever possible.

<table>
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<tr>
<th>Requested Medication (Include strength and dosage formulation)</th>
<th>Diagnosis</th>
<th>ICD-10 Codes</th>
<th>Preferred Product (Yes/No)</th>
<th>Requested Quantity Per Month</th>
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**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:** ____________________

**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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