



STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

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

Magnolia Health/Envolv 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>

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/>

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): _____	
<input type="checkbox"/> Hospital Discharge	<input type="checkbox"/> 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	
<i>Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)</i>	
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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PRIOR AUTHORIZATION DESCRIPTION



MAXIMUM UNIT OVERRIDE

- In accordance with state law, Medicaid provides up to a 31-day supply of medications.
- The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose.
- Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at <http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/>
- Medicaid may request chart documentation for verification of submitted information.

Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:

- The request must be substantiated by diagnosis and supporting medical justification.
- Supporting documentation must be available in the patient record.
- Medication will not be approved for non-FDA approved indications.

CRITERIA/ADDITIONAL DOCUMENTATION

MAXIMUM UNIT OVERRIDE



BENEFICIARY INFORMATION	
Beneficiary ID: _____ - _____ - _____	DOB: ____/____/____
Beneficiary Full Name: _____	
Maximum Unit Override Request	
<ul style="list-style-type: none"> In accordance with state law, Medicaid provides up to a 31-day supply of medications. The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose. Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/ Medicaid may request chart documentation for verification of submitted information. <p>Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:</p> <ul style="list-style-type: none"> The request must be substantiated by diagnosis and supporting medical justification. Supporting documentation must be available in the patient record. Medication will not be approved for non-FDA approved indications. <p>1. Specific diagnosis and ICD-10 code(s): _____</p> <p>2. If dosing is weight-based or body surface area-based: Beneficiary's Weight: _____ Beneficiary's Height: _____</p> <p>3. Detailed description of reason beneficiary needs a greater quantity allowed than quantity limit or dose greater than what the FDA approved label recommends: _____ _____ _____</p>	
Printed Name of Prescribing Provider: _____ Date: _____	

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