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

<table>
<thead>
<tr>
<th>BENEFICIARY INFORMATION</th>
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<tbody>
<tr>
<td>Beneficiary ID: _______ ______ - ______ ______ - ______ ______</td>
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<tr>
<td>DOB: ______ / ______ / ______</td>
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<tr>
<td>Beneficiary Full Name:</td>
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<thead>
<tr>
<th>PRESCRIBER INFORMATION</th>
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<tbody>
<tr>
<td>Prescriber’s NPI:</td>
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<tr>
<td>Prescriber’s Full Name:</td>
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<tr>
<td>Phone:</td>
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<tr>
<td>Prescriber’s Address:</td>
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<tr>
<td>FAX:</td>
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<tr>
<th>PHARMACY INFORMATION</th>
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<tbody>
<tr>
<td>Pharmacy NPI:</td>
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<tr>
<th>CLINICAL INFORMATION</th>
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<tbody>
<tr>
<td>Requested PA Start Date: ___________________ Requested PA End Date: ___________________</td>
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<tr>
<td>Drug/Product Requested: ___________________ Strength: ______ Quantity: ______</td>
</tr>
<tr>
<td>Days Supply: ______ RX Refills: ________ Diagnosis or ICD-10 Code(s): ___________________</td>
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☐ 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
PRIOR AUTHORIZATION DESCRIPTION

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
**CRITERIA/ADDITIONAL DOCUMENTATION**

**PREFERRED DRUG EXCEPTION**

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### BENEFICIARY INFORMATION

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**Beneficiary Full Name:**

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### 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/](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 product(s)?
   - YES
   - NO

   **1st Drug:** ___________________________________
   **Length of Therapy:** ________________________
   **Reason for D/C:** ____________________________

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

   **If YES, list the condition/issue(s):** __________________________
   ________________________________________________________________________________

3. Is there a potential drug interaction between another medication and the preferred product(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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**FAX THIS PAGE**