



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

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



BENEFICIARY INFORMATION

Beneficiary ID: _____ - _____ - _____	DOB: ____/____/____
Beneficiary Full Name: _____	

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/>. 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 products(s)? YES NO

1st Drug: _____ Length of Therapy: _____

Reason for D/C: _____

2nd Drug: _____ Length of Therapy: _____

Reason for D/C: _____

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.

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

If YES, list the condition/issue(s): _____

3. Is there a potential drug interaction between another medication and the preferred products(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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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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