



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): _____	
<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: _____	

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.

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-833-660-2402) or fax (1-866-644-6147) and destroy all copies of the original message.
10/1/2022

CRITERIA/ADDITIONAL DOCUMENTATION UNIVERSAL PRIOR AUTHORIZATION REQUEST



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

Universal Prior Authorization Request

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at <https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/>. 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. Is the diagnosis for the agent requested a FDA approved indication?

- Yes (see # 2) No (see # 3) If no, then please sign the following waiver:

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

See waiver signature required at the end of form to attest that the medical necessity outweighs the risk for this/these medication(s).

2. Is there a preferred agent on the PDL used for the treatment for this diagnosis?

- Yes (see #3) No (see #4)

3. Has the patient experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects?

If Yes, please give a detailed explanation: _____

1st Drug: _____

Length of Therapy: _____

2nd Drug: _____

Length of Therapy: _____

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.

4. Please provide the treatment plan for this diagnosis including, but not limited to: pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.

Printed Name of Prescribing Provider: _____ Date: _____

If applicable, please attest to waiver by checking box and providing your signature below:

- Waiver: I attest that the medical necessity outweighs the risk for this/these medication(s).

Signature: _____ 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.

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-833-660-2402) or fax (1-866-644-6147) and destroy all copies of the original message. 10/11/2022