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/

☐ 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: <strong><strong><strong><strong>-</strong></strong><strong>-</strong></strong></strong>-______  DOB: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
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<tr>
<td>Beneficiary Full Name:</td>
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<tr>
<th>PRESCRIBER INFORMATION</th>
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<tr>
<td>Prescriber’s NPI:</td>
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<tr>
<td>Prescriber’s Full Name:</td>
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<tr>
<td>Prescriber’s Address:</td>
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<tr>
<td>Phone:</td>
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<tr>
<td>FAX:</td>
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<tr>
<th>PHARMACY INFORMATION</th>
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<tr>
<td>Pharmacy NPI:</td>
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<tr>
<td>Pharmacy Name:</td>
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<td>Pharmacy FAX:</td>
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<tr>
<th>CLINICAL INFORMATION</th>
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<tr>
<td>Requested PA Start Date: ________________  Requested PA End Date: ________________</td>
</tr>
<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

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 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: ___________________________

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