MISSISSIPPI DIVISION OF MEDICAID

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**/Express Scripts
Fax to: 1-844-205-3387 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.uhccommunityplan.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):_____

☐ **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 INFORMATION

Brand-Name Multi-Source Drug / Dispense As Written (DAW)

The following brand name drugs are excluded from this requirement:

- ***DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.***
- ***Preferred branded drugs on DOM's PDL.***

The completed FDA MedWatch form must be included with this request. *A copy of the FDA MedWatch form may be obtained online at:*
http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries

The Division of Medicaid has established a program of Early and Periodic Screening., Diagnosis, and Treatment (EPSDT), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to the age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. See MS Administrative Code, Title 23, Part 223.

Reasons for prior authorization request may include, but are not limited to:
Request for more than 5 prescription claims per month
Request for more than 2 non-preferred/brand name prescription claims per month
Request for a non-preferred drug
Request for a non-covered drug

CRITERIA/ADDITIONAL DOCUMENTATION
BRAND NAME MULTI-SOURCE DRUG

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION

Beneficiary ID:____ ____ ____ - ____ ____ ____ - ____ ____ ____ **DOB:**____ ____/____ ____/____ ____ ____ ____

Beneficiary Full Name:

Brand Name Multi-Source Drug / Dispense As Written (DAW) Criteria

MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval

The following brand name drugs are excluded from this requirement:

- ***DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.***
- ***Preferred branded drugs on DOM's PDL.***

The completed FDA MedWatch form must be included with this request. *A copy of the FDA MedWatch form may be obtained online at:* http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product:_____ **Manufacturer:**_____ **Length of Therapy:**_____

Observed adverse reaction or allergic reaction:_____

_____

_____

Documentation Included: ☐ **Yes** ☐ **No**

Generic Product:_____ **Manufacturer:**_____ **Length of Therapy:**_____

Observed adverse reaction or allergic reaction:_____

_____

_____

Documentation Included: ☐ **Yes** ☐ **No**

Has a completed FDA MedWatch form been submitted to the FDA? ☐ **Yes** ☐ **No**

Printed Name of Prescribing Provider:_____ **Date:**_____

FAX THIS PAGE