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:_____**

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# CRITERIA/ ADDITIONAL DOCUMENTATION
# EPSDT MEDICAL NECESSITY

MISSISSIPPI DIVISION OF MEDICAID

| BENEFICIARY INFORMATION | |
|---|---|
| **Beneficiary ID:**____ ____ ____ - ____ ____ ____ - ____ ____ ____ | **DOB:**____ ____ /____ ____ /____ ____ ____ ____ |
| **Beneficiary Full Name:** | |

## Medical Necessity for EPSDT-eligible beneficiaries Request

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 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 6 prescription claims per month
- ☐ Request for more than 2 non-preferred/brand name prescription claims per month
- ☐ Request for waiver with provider attestation (see waiver at bottom of form)
- ☐ Request for non-covered medication (drug not federally rebated)
- ☐ Other: example, drug closed to pharmacy coverage and covered as a medical claim

***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.*

| Requested Medication (Include strength and dosage formulation) | Diagnosis | ICD-10 Codes | Preferred Product (Yes/No) | Requested Quantity Per Month |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

**Medical Necessity:** _____

_____

**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

However, I attest that the medical necessity outweighs the risk for this/these medication(s).

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

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