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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PRIOR AUTHORIZATION DESCRIPTION

MAXIMUM UNIT OVERRIDE

- In accordance with state law, Medicaid provides up to a 31-day supply of medications.
- The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose.
- Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/
- Medicaid may request chart documentation for verification of submitted information.

Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:
• The request must be substantiated by diagnosis and supporting medical justification.
• Supporting documentation must be available in the patient record.
• Medication will not be approved for non-FDA approved indications.

CRITERIA/ADDITIONAL DOCUMENTATION
MAXIMUM UNIT OVERRIDE

MISSISSIPPI DIVISION OF MEDICAID

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

Maximum Unit Override Request

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- Supporting documentation must be available in the patient record.
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1. Specific diagnosis and ICD-10 code(s):
   _____
2. If dosing is weight-based or body surface area-based:

   Beneficiary's Weight: _____ Beneficiary's Height: _____
3. Detailed description of reason beneficiary needs a greater quantity allowed than quantity limit or dose greater than what the FDA approved label recommends:

_____

_____

_____

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

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