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

## Multiple Antipsychotics for Patients Less Than Age 18 Years

### (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications)

**BENEFICIARY INFORMATION**

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

**Beneficiary Full Name:**

**Antipsychotics (Multiple) for Patients Less Than Age 18 Years**

**Gender:** ☐ Male ☐ Female **Age:**_____ **Medication Request:** ☐New ☐Continuation

**Beneficiary under State Care/Custody**: ☐ Yes ☐ No ☐ Unknown

**Diagnosis:** *(check all that apply)*

☐ ADHD ☐ Autism Spectrum ☐ Bipolar Disorder ☐ Disruptive Behavior Disorder

☐ Disruptive Mood Dysregulation Disorder ☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Tourette's

Other: _____

**Height:** _____ in. ***OR*** _____cm. **Weight:** _____ lb. ***OR*** _____kg. **BMI**: _____

**Target Symptoms: (check all that apply)** ☐ Aggression ☐Impulsivity ☐Irritability

Mood Instability: ☐ Depression ☐Mania ☐ Psychosis ☐ Self-Injurious Behavior ☐ Other: _____

**Overall Target Symptoms Severity:** ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

**Functional Impairment:** ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

**List All Current Medications:**_____

| Antipsychotic Requested | Strength | Directions | Quantity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ Yes ☐ No ☐ NA If prescribing more than one (1) antipsychotic, is the plan to cross taper, with antipsychotic dual/monotherapy resumed within the next ninety (90) days? (if applicable)

**IF YES**: Which of the medication(s) listed above will be discontinued?_____

**IF NO**: What is the rationale for continuing treatment with two (2) or more antipsychotics? _____

☐Yes ☐ No Beneficiary has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies, such as, but not limited to, evidence based behavioral, cognitive, and family based therapies.

☐ Yes ☐ No Beneficiary is currently receiving non-pharmacologic/psychosocial services.

☐ Yes ☐ No For a beneficiary not currently receiving non-pharmacologic/psychosocial services, a referral has been made and an appointment is pending. If there is no pending appointment, provide explanation below:

_____

_____

Has an assessment for Extrapyramidal Symptoms, including Tardive Dyskinesia (TD) been done in the last 26 weeks (6 months)? **AIMS**: ☐Yes ☐No ***OR*** **DISCUS**: ☐Yes ☐No **AIMS/DISCUS Forms**

☐ Yes ☐ No Medical record documentation of metabolic monitoring: weight or BMI, blood pressure, fasting glucose, and a fasting lipid panel within the last 12 months.

**Next appointment date**: _____

***I certify that the benefits of antipsychotic treatment outweigh the risks of treatment.***

**Prescriber's Signature:** _____ **Specialty:** _____

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