STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, Gainwell Technologies, PO Box 2480, Ridgeland, MS 39158

Medicaid Fee for Service/MSCAN/MSCHIP Members
Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
Pharmacy Prior Authorization - Mississippi Division of Medicaid (ms.gov)

Submit your PA requests via the MESA (Medicaid Enterprise System Assistance) provider portal for the most efficient processing
Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com)

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

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.

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CRITERIA/ ADDITIONAL DOCUMENTATION
EPSDT MEDICAL NECESSITY

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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