MISSISSIPPI DIVISION OF MEDICAID

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

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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