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
UNIVERSAL PRIOR AUTHORIZATION REQUEST

MISSISSIPPI DIVISION OF MEDICAID

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

Universal Prior Authorization Request

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/*.Medicaid providers are encouraged to use equally efficacious and cost-saving preferred agents whenever possible. Prior drugs used must be reflected in paid pharmacy claims.*

1. Is the diagnosis for the agent requested a FDA approved indication?

☐ Yes (see # 2) ☐ No (see # 3) If no, then please sign the following waiver:

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

See waiver signature required at the end of form to attest that the medical necessity outweighs the risk for this/these medication(s).

2. Is there a preferred agent on the PDL used for the treatment for this diagnosis?

☐ Yes (see #3) ☐ No (see #4)

3. Has the patient experienced any of the following regarding use of the preferred product(s): treatment failure, a condition that prevents use, a potential drug interaction, and/or intolerable side effects?

If Yes, please give a detailed explanation: _____

_____

_____

1st Drug: _____ Length of Therapy:_____

2nd Drug: _____ Length of Therapy:_____

Attach additional documentation of other treatment failures with preferred drugs if necessary. If no previous preferred drug usage, then additional medical justification must be provided.

4. Please provide the treatment plan for this diagnosis including, but not limited to: pertinent medical history, relevant lab values, concurrent medications, treatment tried and reason (if known) for failure.

_____

_____

5. Is this a request for more than 6 prescriptions per month for an adult (over age 21)? ☐ YES ☐ NO

If yes, please attach a complete medication listing (including medication name, strength, dosage formulation) and medical necessity justification.

6. Has the provider reviewed and utilized the 90-day maintenance list as a tool to manage the beneficiary's monthly prescription drug limit? ☐ YES ☐ NO **If NO**, please give an explanation: _____

_____

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

If applicable, please attest to waiver by checking box and providing your signature below:

☐ **Waiver: I attest that the medical necessity outweighs the risk for this/these medication(s).**

Signature: _____ **Date:** _____

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