



# 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/MCHIP Members  
Gainwell Technologies

Fax to: 1-866-644-6147 Ph: 1-833-660-2402

[Pharmacy Prior Authorization - Mississippi Division of Medicaid \(ms.gov\)](http://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 \(ms-medicaid-mesa.com\)](http://Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com))

|  |                            |
|--|----------------------------|
| <b>BENEFICIARY INFORMATION</b>   |                            |
| Beneficiary ID: _____ - _____ - _____  | DOB: _____ / _____ / _____ |
| Beneficiary Full Name: _____   |                            |
| <b>PRESCRIBER INFORMATION</b>  |                            |
| Prescriber's NPI: _____  |                            |
| Prescriber's Full Name: _____  | Phone: _____               |
| Prescriber's Address: _____  | FAX: _____                 |
| <b>PHARMACY INFORMATION</b>  |                            |
| Pharmacy NPI: _____  |                            |
| Pharmacy Name: _____   |                            |
| Pharmacy Phone: _____  | Pharmacy FAX: _____        |
| <b>CLINICAL INFORMATION</b>  |                            |
| Requested PA Start Date: _____ Requested PA End Date: _____  |                            |
| Drug/Product Requested: _____ Strength: _____ Quantity: _____  |                            |
| Days Supply: _____ RX Refills: _____ Diagnosis or ICD-10 Code(s): _____  |                            |
| <input type="checkbox"/> Hospital Discharge <input type="checkbox"/> Alyce G. Clarke Center for Medically Fragile Children<br><input type="checkbox"/> Additional Medical Justification Attached |                            |
| Medications received through coupons and/or samples are not acceptable as justification  |                            |
| <b>PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW</b>  |                            |
| <i>Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)</i>  |                            |
| 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 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<br>(Include strength and dosage formulation) | Diagnosis | ICD-10<br>Codes | Preferred<br>Product<br>(Yes/No) | Requested<br>Quantity<br>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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