



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 \(ms.gov\)](http://ms-medicaid-mesa.com)

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://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	
<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: _____	

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.

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-833-660-2402) or fax (1-866-644-6147) and destroy all copies of the original message.

10/01/2026

PRIOR AUTHORIZATION DESCRIPTION



MAXIMUM UNIT OVERRIDE

- In accordance with state law, Medicaid provides up to a 31-day supply of medications.
- The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose.
- Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at <https://medicaid.ms.gov/pharmacy/pharmacy-resources/>
- Medicaid may request chart documentation for verification of submitted information.

Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:

- The request must be substantiated by diagnosis and supporting medical justification.
- Supporting documentation must be available in the patient record.
- Medication will not be approved for non-FDA approved indications.

CRITERIA/ADDITIONAL DOCUMENTATION MAXIMUM UNIT OVERRIDE



BENEFICIARY INFORMATION

Beneficiary ID: _____ - _____ - _____

DOB: ____/____/____

Beneficiary Full Name: _____

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1. Specific diagnosis and ICD-10 code(s): _____

2. If dosing is weight-based or body surface area-based:

Beneficiary's Weight: _____ Beneficiary's Height: _____

3. Detailed description of reason beneficiary needs a greater quantity allowed than quantity limit or dose greater than what the FDA approved label recommends:

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 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

If applicable, please attest to the EPSDT waiver by checking the box below:

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

Printed Name of Prescribing Provider: _____ Date: _____

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