MISC/NON-PREF.9
Form # 20420
R: 09.08

State of Maine Department of Health &Human Services
MaineCare/MEDEL Prior Authorization Form

MISCELLANEOUS/NON-PREFERRED DRUGS SUBJECT TO PA

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| Patient Name: ______________________________________ DOB: __________________
(NOT MEDICARE NUMBER)

Patient Address:____

Provider DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:____ Phone:_____________________

Provider Address:____ Fax:_____________________

Pharmacy Name:______________________________Rx Address:_________________________________Rx phone:_________________

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Refills
____________________________	__________	____________	__________	______________	1 2 3 4 5

Medical Necessity Documentation Required: (Attach copies of supporting office notes.)

Why is this medication necessary for this member? (Please include members medical diagnosis)

____

____

If applicable, what other "preferred" or "more preferred" alternatives were tried first?

____

____

Explain why each untried "preferred" alternative is unsuitable or less desirable:

____

____

--Pertinent Lab Data ____

- ❑ If requesting oral nutritional supplement, include copy SGA form
- ❑ WIC Eligible (for nutritionals)? __________(Y/N)
- ❑ If requesting Alzheimer medication, include copy of MMSE

Certification to seek exception from chart documentation requirement:
I certify that (a) the information provided is accurate and complete to the best of my knowledge, and (b) that any required supporting medical record documentation is physically or electronically accessible and satisfies the explicitly posted relevant PDL criteria. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. As per MaineCare Benefits Manual, Chapter I, Sections 1.16 and 1.19, "sanctions" (including recouping payments previously made) "may be imposed by the Department against a provider submitting false information for the purpose of meeting prior authorization requirements."

Provider Signature: ______________________________________ Date of Submission: ________________________________
***MUST MATCH PROVIDER LISTED ABOVE**

OR

Made Fillable by eForms

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: ______________________________________ Date of Submission: ________________________________
***MUST MATCH PROVIDER LISTED ABOVE**