Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Request for Rx Prior Authorization

Do Not Use for Antipsychotic Requests

Please check the appropriate box for the Prior Authorization request.

☐ Quantity Limit Override ☐ Age Override ☐ Non-Preferred ☐ Clinical Criteria ☐ Other _____

Please provide rationale for this request: _____

_____

_____

To find an **alternative drug** that is available **without prior approval**, see the Department's Preferred Drug list at: https://mmcp.dhmh.maryland.gov/pap/SitePages/Preferred%20Drug%20List.aspx

Date __ __ - __ __ - __ __

Patient's Information (required): Name: _____

DOB: _____ Recipient's Maryland Medicaid Number: _____

Prescriber's Information (required): Name: _____

NPI #: _____ Phone #: _____ Fax #: _____

Contact Person for this Request (required): Name: _____

Phone: _____ Fax: _____

- **Use a separate form for EACH medication request** -

- **Medication**: _____ **Strength**: _____ **Quantity**: ____ **Refills**: ____

  ☐ New Prescription ☐ Refill (Patient has been taking this medication)

Note: If the generic is not acceptable, the prescriber must complete a DHMH MedWatch Form.
https://mmcp.dhmh.maryland.gov/pap/SitePages/[DHMH]%20Medwatch%20Form.aspx

- **Directions for Use**: _____ Length of Treatment _____

  1. Diagnosis/Indication: _____

Prescriber's Signature_____ Date_____

To encourage the safe and appropriate use of drugs while containing costs, **clinical criteria have been developed for some medications**. To view clinical criteria, select this link: https://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx

Fax this completed form to 866-440-9345, once all the required information has been provided**. Incomplete forms will be returned.**

Made Fillable by eForms