

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM



Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit,
550 High St., Suite 1000, Jackson, MS 39201

Medicaid Fee for Service/Change Healthcare
Fax to: 1-877-537-0720 Ph: 1-877-537-0722
<https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/>

Magnolia Health/Envolv Pharmacy Solutions
Fax to: 1-866-399-0929 Ph: 1-866-399-0928
<https://www.magnoliahealthplan.com/providers/pharmacy.html>

UnitedHealthcare/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
<http://www.uhcommunityplan.com/health-professionals/ms/pharmacy-program.html>

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

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.

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CRITERIA/ADDITIONAL DOCUMENTATION PREFERRED DRUG EXCEPTION



BENEFICIARY INFORMATION

Beneficiary ID: _____ - _____ - _____ DOB: ____/____/____

Beneficiary Full Name: _____

Preferred Drug List Exception Criteria/Additional Documentation

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.

Prior drugs used must be reflected in paid pharmacy claims.

1. Has the patient experienced treatment failure with the preferred products(s)? YES NO

1st Drug: _____ Length of Therapy: _____

Reason for D/C: _____

2nd Drug: _____ Length of Therapy: _____

Reason for D/C: _____

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.

2. Does the patient have a condition that prevents the use of the preferred products(s)?..... YES NO

If YES, list the condition/issue(s): _____

3. Is there a potential drug interaction between another medication and the preferred products(s)?..... YES NO

If YES, list the interaction(s): _____

4. Has the patient experienced intolerable side effects while on the preferred product(s)? YES NO

If YES, list the side effects(s): _____

Printed Name of Prescribing Provider: _____ Date: _____

*MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.

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