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/Envolve 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.uhccommunityplan.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

CRITERIA/ADDITIONAL DOCUMENTATION
PREFERRED DRUG EXCEPTION

MISSISSIPPI DIVISION OF MEDICAID

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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