



Preferred Drug List Exception Request

Division of Medicaid
State of Mississippi
239 N. Lamar Street, Suite 801
Jackson, Mississippi 39201

Administered by
Health Information Designs (HID)
Fax, Phone, Mail Completed form to:
Fax: 1-800-459-2135
Phone: 1-800-355-0486
P.O. Box 320506
Flowood, MS 39232

Patient Name (Last) (First) MI	MS Medicaid 9 Digit ID #:	Date of Birth
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Practitioner Name (Last) (First) (MI)	Practitioner Provider Number
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Practitioner Address (Street) (City) (State) (Zip)	Phone #
	Fax #

Pharmacy Name & Address (City) (State)	Provider Number	Phone#
		Fax #

Non-Preferred Drug Requested	Dose	Directions
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Diagnosis	(Optional) Diagnosis Code (ICD-9-CM)
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Please answer each of the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the 2 preferred products(s)? Yes No
1st Drug _____ Length of Therapy _____ Reason for D/C _____

2ndDrug _____ Length of Therapy _____ Reason for D/C _____

2. Does the patient have a condition that prevents the use of the preferred products(s)? Yes No
If YES, list the interaction(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred products(s)? Yes No
If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? Yes No
If YES, list the side effects in the box below:

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

Practitioner Signature: _____ **Date:** _____

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