



PHARMACY PRIOR AUTHORIZATION FORM

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

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: [grid]
Beneficiary Full Name: _____ DOB: _____
Prescriber NPI: [grid]
Prescriber's Full Name: _____ Phone: _____
Prescriber's Address: _____ FAX: _____
Pharmacy NPI: [grid]
Pharmacy Name: _____
Phone: _____ FAX: _____

CLINICAL INFORMATION
PA Start Date _____ End Date _____
Drug Requested _____ Strength _____ Quantity _____
Days Supply _____ RX Refills _____ Diagnosis or ICD-9 Code _____
[] Hospital Discharge [] Additional Medical Justification Attached
Medications received through coupons and/or samples are not acceptable as justification.
DRUG SPECIFIC INFORMATION
[] Brand Name Multi Source (Must include MedWatch page and Brand Name Multi Source Page 2 from instructions)
[] Early Refill (Must include Early Refill Page 2 from instructions)
[] Enteral Nutrition (Must include Enteral Page 2 from instructions)
[] Max Unit Override (Must include Max Override Page 2 from instructions)
[] Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries (Must include Children's Page 2 from instructions)
[] Preferred Drug List Exception Request (Must include Preferred Drug List Exception Page 2 from instructions)
[] Solvaldi Initial Therapy (Months 1-2) or Solvaldi Ongoing Therapy (Must include Solvaldi Initial or Ongoing Therapy Page 2 from instructions)
[] Synagis (Must include Synagis Page 2 from instructions)
[] Appeal/Reconsideration (Must include Appeal/Reconsider information page 2 from Instructions)
MUST SUBMIT PAGE TWO
Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)
Signature required: _____ Date: _____
Printed name of prescribing provider: _____

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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As of January 1, 2014 and in order for DOM to be in compliance with state law, submissions on forms used previously can no longer be accepted for Medicaid beneficiaries and will be returned to the prescriber.

PA Determination

If the Pharmacy PA unit approves the prior authorization, the beneficiary can return to their pharmacy to obtain the prescription. The drug claim will pay and no further action will be required.

If the Pharmacy PA denies the request, the prescriber’s office will be notified immediately. The prescriber has the option of prescribing a different treatment course that does not require prior authorization or submitting the required form.

REMINDER: Before submitting a PA request, check for options not requiring PA on the current PDL found at <http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/> Medicaid providers are encouraged to use equally efficacious and cost saving **preferred** agents whenever possible.

NOTICE: Instructions for successfully completing a Prior Authorization Form

Prior Authorization Page 1 along with ONE of the pages below must be completed and faxed in for prior authorization.

Drug Specific Information:

| | |
|---|----------|
| Brand Name Multi Source | Page 2.A |
| Early Refill | Page 2.B |
| Enteral Nutrition | Page 2.C |
| Max Unit Override | Page 2.D |
| Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries | Page 2.E |
| Preferred Drug List Exception Request | Page 2.F |
| Solvaldi Initial Therapy (Months 1–2) or Solvaldi Ongoing Therapy | Page 2.G |
| Synagis | Page 2.H |
| Appeal/Reconsideration | Page 2.I |

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Beneficiary Full Name: _____

Brand-Name Multi-Source Drug / Dispense As Written (DAW)* Form 2A

PRIOR AUTHORIZATION REQUEST FORM

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

The following brand name drugs are excluded from this requirement:

- **DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.**
- **Preferred branded drugs on DOM's PDL.**

The completed FDA MedWatch form must be included with this request. A copy of the FDA MedWatch form may be obtained online at: <http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf>

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product: _____ Manufacturer: _____

Length of therapy _____

Observed adverse reaction or allergic reaction:

Generic Product: _____ Manufacturer: _____

Length of therapy _____

Observed adverse reaction or allergic reaction:

Documentation Included: Yes No

Has a completed FDA MedWatch form been submitted to FDA: Yes No?

PAGE 2.A

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Beneficiary Full Name: _____

Early Refill Pharmacy Prior Authorization Form* Form 2B

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

- No early refill can be authorized if the beneficiary's monthly service limit has been reached.
- MS Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.
- MS Medicaid does not pay for vacation supplies.
- Current policy requires at least:
 - 75% of a non-controlled substance prescription claim's day's supply to transpire to pay or a PA request to be approved; or
 - 85 % of a controlled substance prescription claim's day's supply to transpire to pay or a PA request to be approved.

Reason for Request:

- Prescriber increased the dosing frequency
- Prescriber increased the number of units per dose
- New Admission to Nursing Home
- Extra medication needed to stop or mitigate further morbidity due to acute clinical Condition.

Explanation: _____

- Lost or Stolen: Documentation required**
- Destroyed (fire, natural disaster, such as flood tornado, hurricane): Documentation required**
- Other, **Specify:** _____

Additional Comments:

*The pharmacist should maintain documentation for each early refill override that is obtained from **DOM**.
 ** Documentation must be provided for prescriptions for controlled substances and/or medication with a potential for abuse or resale. Examples of documentation include a police report, insurance report, etc.
 ***Supporting documentation must be available in the patient record

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Beneficiary Full Name: _____

Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries Form 2E

The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to the age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. See MS Administrative Code, Title 23, Part 223.

Reasons for prior authorization request may include, but are not limited to:

- Request for more than 5 prescription claims per month
- Request for more than 2 non-preferred/brand name prescription claims per month
- Request for non-preferred medication
- Request for a non-covered drug

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at <http://www.medicaid.ms.gov/Pharmacy.aspx>. Medicaid providers are encouraged to use equally efficacious and cost saving **preferred** agents whenever possible.

| Requested Medication (Include strength and dosage formulation) | Diagnosis | Preferred Product (Yes/No) | Requested Quantity Per Month |
|--|-----------|----------------------------------|------------------------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

Additional Medical Justification, including age waiver, if applicable:

PAGE 2.E

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Beneficiary Full Name: _____

Preferred Drug List Exception Pharmacy Prior Authorization Form Form 2F

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at <http://www.medicaid.ms.gov/Pharmacy.aspx>. Medicaid providers are encouraged to use equally efficacious and cost saving preferred agents whenever possible.

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 interaction(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: _____

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PAGE 2.F

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Beneficiary

ID#: Beneficiary Full Name: _____

Sovaldi® INITIAL THERAPY PA Request

Form 2G Section 3

The following documentation must be submitted with initial request for consideration of approval:

| | |
|--|---|
| <input type="checkbox"/> Active HCV infection verified by viral load within the last year | <input type="checkbox"/> HCV Genotype verified by lab |
| <input type="checkbox"/> Prescriber is, or has consulted with, a gastroenterologist, hepatologist, ID specialist or other Hepatitis specialist. Requires consult within the past year with documentation of recommended regimen | <input type="checkbox"/> Documentation of counseling regarding abstinence from alcohol, IV drug use and education on how to prevent HCV transmission. Documentation of abstinence from drugs and alcohol for at least 6 months; negative urine drug screen required if there is a history of IV drug use. |
| <input type="checkbox"/> Patient is not receiving dialysis and has CrCl \geq 30mL/min <input type="checkbox"/> Verified by lab results including a creatinine level within the past 6 months | <input type="checkbox"/> Current medication list that does NOT include: carbamazepine, phenytoin, Phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort or tipranavir. |
| <input type="checkbox"/> For women of childbearing potential (and male patients with female partners of childbearing potential): <input type="checkbox"/> Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of stopping <input type="checkbox"/> Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after stopping <input type="checkbox"/> Verification that monthly pregnancy tests will be performed throughout treatment | |
| <input type="checkbox"/> For IFN-Intolerant* (for use with regimens 4, 5, 6 or Other if applicable): <input type="checkbox"/> Documented life-threatening side effects or potential side effects (i.e. history of suicidality) <input type="checkbox"/> Decompensated cirrhosis (Child-Pugh >6) • Or Child-Pugh ≥ 6 if co-infected with HIV <input type="checkbox"/> Blood dyscrasias: • Baseline neutrophil count $<1500/\mu\text{L}$, baseline platelets $<90,000/\mu\text{L}$ or baseline Hgb $<10\text{g/dL}$ <input type="checkbox"/> Pre-existing unstable or significant cardiac disease (e.g. history of MI or acute coronary syndrome) <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> FOR REGIMEN 7: Transplant date: _____ <input type="checkbox"/> Not yet scheduled | |

Provider Signature: _____

Date of Submission: _____

***MUST MATCH PROVIDER LISTED ON PAGE ONE**

**PAGE 2.G
Section 3**

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Grid for Beneficiary ID#

Beneficiary Full Name: _____

Sovaldi® ONGOING THERAPY PA Request Form 2G Section 4

Mississippi Division of Medicaid will approve Sovaldi® PA requests for members who meet the following guidelines. The Initial PA must be approved prior to the 1st dose. This ONGOING THERAPY PA FORM must be completed for each month of therapy after first 8 weeks (First 8 weeks are covered on Initial Therapy PA Request).

REGIMEN BEING USED:

- 1. Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG x84 days (12 weeks)
2. Sovaldi 400mg daily w/ weight-based RBV plus weekly PEG x84 days (12 weeks)
a. With an additional 84 days (12 weeks) of PEG/RBV to follow
3. Sovaldi 400mg daily w/ weight-based RBV x84 days (12 weeks)
4. Sovaldi 400mg daily w/ weight-based RBV x112 days (16 weeks)
5. Sovaldi 400mg daily PLUS Olysio 150mg daily w/ or w/out weight-based RBV x84 days (12 weeks)
6. Sovaldi 400mg daily w/ weight-based RBV x164 days (24 weeks)
7. Sovaldi 400mg daily w/ weight-based RBV (for up to 48 weeks or until liver transplant)

OTHER:

Please provide clinical rationale for choosing a regimen that is beyond those found within the current guidelines, or for selecting any of the above regimens for alternate genotypes/patient populations.

Sovaldi 400mg daily w/ _____ x _____ days (_____ weeks)

- Patient has remained compliant (>85%) on all medications throughout first 2 months of treatment, AND
Documentation is attached giving evidence of said compliance in the form of:
- Week-4 Viral Load showing a LOG decrease in HCV viral RNA, OR
- Chart notes from an office visit documenting an appropriate compliance discussion, OR
- Other appropriate lab value (with clinical rationale for use):
Patient is a woman of child-bearing potential
- Monthly pregnancy tests have been performed with negative results, AND
- Patient agrees to continue use of two forms of effective non-hormonal contraception
FOR REGIMEN 7: Transplant date:
Not yet scheduled

Provider Signature: _____ Date of Submission: _____

*MUST MATCH PROVIDER LISTED ONE PAGE ONE

PAGE 2.G
Section 4

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Grid for Beneficiary ID#

Beneficiary Full Name: _____

Synagis Prior Authorization Form* Form 2H

Injections approved starting October 28, 2014 - March 31, 2015 for a maximum of up to 5 injections

PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes approved pharmacy providers from the 2013-2014 seasons. If the approved provider for this request is not included in this list, please select other and provide pharmacy provider information (name, address, telephone number, Medicaid provider number, etc.).

- Checkboxes for Lincare, MEDFUSION (BriovaRx), NMMC, UMC, VitalCare, and Other NPI with fields for PH and Fax.

NDC#: _____ Gestational Age: _____ Wks.: _____ Days: _____ Birth Weight: _____ lbs. _____ oz.

Current Weight: _____ lbs. _____ oz. Date last weighed: _____

Did the patient receive Synagis in the hospital? Yes ___ No ___ if yes, list date(s) of administration:

Table with 2 columns: Age ≤ 1 year at start of RSV season and one of the following; Age 12 – 24 months at start of RSV season and one of the following. Includes criteria for prematurity, chronic lung disease, hemodynamically significant CHD, congenital abnormalities, cystic fibrosis, and immunocompromise.

Mississippi Medicaid is a federally-subsidized health care program funded with public dollars. As such, I confirm that this medication will be administered to the patient for whom it is dispensed. If I or my staff are unable to administer this medication to the designated patient, I acknowledge that I am responsible for notifying the dispensing pharmacy immediately

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Beneficiary Full Name: _____

PHARMACY PRIOR AUTHORIZATION APPEAL/ RECONSIDERATION REQUEST FORM Form 2I

- *MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.*
- *Request must be submitted within 30 (thirty) days form the date of the denial notice.*
- *Medicaid beneficiary or prescriber may submit a written request on this form.*
- *Beneficiary and/or prescriber is encouraged to submit additional information which may affect the appeal review determination.*

PA REQUEST INFORMATION:

Date of Request: _____ Requested By: Prescriber Beneficiary

Date of Denial Notification: _____

RATIONALE/MEDICAL REASON FOR RECONSIDERATION

PAGE 2.I

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