maryland physicians care
Medicaid with a Heart

Return completed request and Medical Record documentation to:
Fax: 800-953-8856
If you have any questions, call:
Phone: 800-953-8854

MEDICAL RX COVERAGE DETERMINATION REQUEST FORM

Patient Name			Prescriber Name	
Member ID #			Prescriber NPI#	Tax ID Number
Sex (circle) **M** **F**	DOB		Office Phone	Office Fax
Height	Weight	Allergies	Servicing Provider (if applicable)	
Contact Person			Servicing Provider NPI#	Tax ID Number

Medication, Strength, & Dose	Route of Admin.	Directions
☐ New Therapy: Date to Start: _____ ☐ Continuation: Date Began: _____		Expected Length of Therapy
Diagnosis for Medication Treatment	ICD10 Code	HCPCS Code
PRESCRIBER'S SIGNATURE (Required)		Date

This section must be completed. Incorrect completion may result in delays in reimbursement or provision of service.

☐ The medical benefit ("Buy and Bill") - **HCPCS CODE:**_____ **Total Billable Units:**_____

Supporting Administration Code(s) - **HCPCS CODE:**_____

Rationale for Exception Request or Prior Authorization (Must attach supporting clinical notes)

☐ Alternate covered drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed MedWatch Form. **Specify:** (1) Covered drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each;

_____

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. **Specify:** (1) Anticipated significant adverse clinical outcome(s) **below**;

☐ Medical need for different dosage form and/or higher dosage; **Specify:** (1) New dosage form; (2) Dosage tried; (3) Documented medical reason

☐ Other:_____(Explain below)

Required Explanation: