maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Egrifta

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 2) [] Continuation (If checked, go to 12)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Is the patient greater than or equal to 65 years of age? [If yes, no further questions.]	Yes	No
4	Is the patient female?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[NOTE: A female is defined as an individual with the biological traits of a female, regardless of the individuals gender identity or gender expression.] [If no, skip to question 7.]		
5	Is the patient currently pregnant? [If yes, no further questions.]	Yes	No
6	Is the patient using a reliable form of birth control (pregnancy category X)? [If no, no further questions.]	Yes	No
7	Does the patient have an active neoplastic disease or acute critical illness? [If yes, no further questions.]	Yes	No
8	Does the patient have disruption of the hypothalamic-pituitary axis (for example, hypothalamic-pituitary-adrenal (HPA) suppression) due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, radiation therapy of the head or head trauma? [If yes, no further questions.]	Yes	No
9	Is the patient at risk for medical complications due to excess abdominal fat? [If no, no further questions.]	Yes	No
10	What is the diagnosis or indication? [] Excess abdominal fat due to lipodystrophy (If checked, go to 11) [] Weight Loss (If checked, no further questions) [] Other (If checked, no further questions)		
11	Does the patient have human immunodeficiency virus (HIV)? [No further questions.]	Yes	No
12	Is there documentation to confirm that the patient has shown a clinical response with the requested medication? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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