maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Global Non-Formulary

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 the requested medication prescribed for an oncology-related condition (such as cancer, leukemia, myelodysplastic syndrome or supportive medications such as anti-emetics or colony-stimulating factors)? [If yes, no further questions.] [NOTE: For oncology-related diagnosis the authorization must be obtained through Eviti Oncology Service at 1-888-678-0990, or www.Eviti.com.]	Yes	No
2	Is the requested medication for the treatment of mental health? [If yes, no further questions.] [NOTE: Medications for mental health conditions are covered by the state. The	Yes	No

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	pharmacy should process the prescription through the mental health pharmacy vendor, Xerox/ACS, bin #610084.]		
3	Is the requested medication prescribed for the treatment of hepatitis C? [If yes, no further questions.] [NOTE: Please call Maryland Physicians Care at 1-800-953-8854 for coverage review.]	Yes	No
4	Is the patient currently receiving the requested medication? [If no, skip to question 10.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 10.]	Yes	No
6	Is the requested drug a Multisource Brand? [Note: The definition of a Multisource Brand is a brand name drug for which a generic is available.] [If no, skip to question 8.]	Yes	No
7	Did the patient experience an intolerance, adverse side effect, or treatment failure to the generic formulation made by TWO different manufacturers? [If no, no further questions.]	Yes	No
8	Is the patient responding to therapy? [If no, no further questions.]	Yes	No
9	Does the patient have an approved PA on file in OnePA/CSP through MPC that has expired within the past 45 days OR will expire within the next 30 days? [If yes, no further questions.]	Yes	No
10	Is the requested medication being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Please document the diagnosis and dose for the requested medication based on the patient's age and indication: _____. [If no, no further questions.]	Yes	No
11	Is the dose of the requested medication appropriate, based on the patient's age and indication? [If no, no further questions.]	Yes	No
12	Is the requested drug a Multisource Brand? [Note: The definition of a Multisource Brand is a brand name drug for which a	Yes	No

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	generic is available.] [If no, skip to question 15.]		
13	Is the generic equivalent of the requested medication on the patient's formulary? [If no, skip to question 15.]	Yes	No
14	Did the patient experience an intolerance, adverse side effect, or treatment failure to the generic formulations made by TWO different manufacturers? Please document any other medications tried, the reason for treatment failure, all drug interactions, contraindications, and/or adverse experiences with other medications with the same indication as the requested product: _____. [If no, no further questions.]	Yes	No
15	Is the request for a combination product for which individual components are available at similar doses on formulary? [If no, skip to question 18.]	Yes	No
16	Has the patient had a trial and failure of the separate individual components due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? [If no, no further questions.]	Yes	No
17	Has a MedWatch Form 3500 been completed and submitted with this request? [If no, no further questions.] [NOTE: Documentation of the Med Watch form must be attached to this case or the request may be denied. The MedWatch form can be obtained from http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf.]	Yes	No
18	Are there other medications IN THE SAME DRUG CLASS available on the formulary to treat the patient's condition? [] Yes (If checked, go to 19) [] No (If checked, no further questions) [] No preferred alternatives exist (If checked, go to 21)		
19	Has the patient tried at least TWO formulary agents IN THE SAME DRUG CLASS (if two formulary agents are available) as the requested medication? [If yes, no further questions.]	Yes	No
20	Does the patient have a contraindication, such as drug allergy or serious drug interaction, to the preferred formulary alternatives IN THE SAME DRUG CLASS? [No further questions.]	Yes	No
21	How many formulary agents has the patient has tried IN THE SAME DRUG CLASS? Please document the formulary status for ALL of the medications the		

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patient has tried for their condition:_____.
[] The patient has tried at least TWO formulary agents (If checked, no further questions)

[] The patient has tried ONE formulary agent and at least 2 preferred alternatives were found (If checked, go to 22)

[] The patient has tried ONE formulary agent and only 1 preferred alternative was found (If checked, no further questions)

[] The patient has not tried any drugs for the condition and at least 1 preferred alternative was found (If checked, go to 22)

[] The patient has not tried any drugs for the condition and NO preferred alternatives were found (If checked, no further questions)

22	Does the patient have a contraindication, such as drug allergy or serious drug interaction, to the preferred formulary alternatives IN THE SAME DRUG CLASS?	Yes	No

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

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.

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