PRIOR AUTHORIZATION REQUEST

Global Quantity Limit

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 a request for INITIAL or CONTINUATION of therapy with the requested medication? Please document the diagnosis or indication AND the quantity for the requested medication per 12 months: _____. [] INITIAL (If checked, go to 4) [] CONTINUATION (If checked, go to 2)		
2	Has the patient been compliant with the treatment regimen? [If no, no further questions.]	Yes	No
3	Has the patient had a response to treatment? [No further questions.]	Yes	No
4	Is this request for quantities that EXCEED the maximum dose established by the FDA for the		

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

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	requested medication? [] Yes (If checked, go to 5) [] No (If checked, go to 10)		
5	Did the patient have an inadequate response to the same medication at a LOWER dosage? [If no, no further questions.]	Yes	No
6	Was medication non-adherence ruled out as a reason for the inadequate response? [If no, no further questions.]	Yes	No
7	Is the patient tolerating the medication at a lower dosage? [If no, no further questions.]	Yes	No
8	Is there documentation of a peer-reviewed journal article that demonstrates the safety and efficacy of the requested dose for the indication? [If yes, no further questions.]	Yes	No
9	Is the requested quantity and dosing supported in medical-accepted compendia? [No further questions.]	Yes	No
	[NOTE: This question must be answered by the prescriber/prescriber's office.]		
10	Is this request for quantities of a LOWER strength that DO NOT EXCEED the maximum dose established by the FDA for the requested medication (for example, two 30mg tablets/day in place of one 60mg tablet/day)? [] Yes (If checked, go to 11) [] No (If checked, go to 15)		
11	Is the dosing due to inadequate response to the optimized dose? [If yes, no further questions.]	Yes	No
	[NOTE: Dose optimization is the use of a higher strength to allow a patient to take fewer doses to achieve the same total daily dose.]		
12	Is the dosing due to patient inability to tolerate total daily dose in one administration? [If yes, no further questions.]	Yes	No
13	Is the dosing based on inability to swallow optimal dose? [If yes, no further questions.]	Yes	No
14	Is there a manufacturer shortage on the optimized strength? [No further questions.]	Yes	No
15	Is this request for quantities for a medication that does NOT have a maximum dose as established by the FDA? [If no, no further questions.]	Yes	No
16	Did the patient have an inadequate response to the SAME medication at a LOWER dosage? [If no, no further questions.]	Yes	No
17	Is the patient tolerating the medication at a LOWER dosage? [If no, no further questions.]	Yes	No

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maryland physicians care
Medicaid with a Heart

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18	Is the requested dose considered medically necessary?	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.

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