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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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

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

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| | | | |
|---|---|---|---|
| | [If yes, no further questions.] | | |
| 4 | Is the patient female?<br>[NOTE: A female is defined as an individual with the biological traits of a female, regardless of the individuals gender identity or gender expression.]<br>[If no, skip to question 7.] | Yes | No |
| 5 | Is the patient currently pregnant?<br>[If yes, no further questions.] | Yes | No |
| 6 | Is the patient using a reliable form of birth control (pregnancy category X)?<br>[If no, no further questions.] | Yes | No |
| 7 | Does the patient have an active neoplastic disease or acute critical illness?<br>[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?<br>[If yes, no further questions.] | Yes | No |
| 9 | Is the patient at risk for medical complications due to excess abdominal fat?<br>[If no, no further questions.] | Yes | No |
| 10 | What is the diagnosis or indication?<br>[] Excess abdominal fat due to lipodystrophy (If checked, go to 11)<br><br>[] Weight Loss (If checked, no further questions)<br><br>[] Other (If checked, no further questions) | | |
| 11 | Does the patient have human immunodeficiency virus (HIV)?<br>[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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Version 07.2025

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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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Version 07.2025