Prior Authorization/Non-Formulary Medication Request

For Hepatitis C, Opioid and Synagis please click the following forms:

Hepatitis C Medication Prior Authorization Form
Opioid Prior Authorization Form
Synagis Prior Authorization Form

All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-Maryland MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274

Patient Name:	**Patient DOB:**
MedStar Family Choice ID # (begins with 91):	**Medicaid ID#:**

Reason for Medication Request:

☐ Prior Authorization	☐ Non-Formulary Medication Request
☐ Increase in Dosage/Frequency	☐ Vacation Supply
☐ Medication Lost/Stolen	☐ Out of Medication
☐ New Diabetic Device	☐ Yearly renewal of Diabetic Device

Medication Requested (*Dose and Frequency*) **or Diabetic Device Requested** (*list all components needed*):

____

****Is the member currently on this medication**: ☐ **Yes** ☐ **No**

Please check that the following clinical has been included with medication request:

☑	**Requirement(s)**
	Last Clinical/Office visit note
	Pertinent Laboratory Findings (if applicable)
	List of Previous Medications Used to Treat Condition:____
	Prior Authorization Table has been checked for medication criteria and submission requirements on: medstarfamilychoice.com/providers/pharmacy
	MedStar Family Choice – Maryland Drug Formulary has been reviewed for alternatives

Diagnosis Code(s) /ICD-10:____

Pharmacy Name:_______________________________________**Phone:** _______________________

*****Please provide all clinical notes to support the request and fax to the number above*****

By signing below, I certify that the information provided is accurate and that all the relevant medical records listed above are included in this submission.

Prescriber Signature: ____ **Date:** __________________

Provider Name/Office:_________________________________**NPI#**________________________________

Provider Phone:______________________________**Provider Fax:** ______________________________

Contact Person Name: ____

Contact Phone w/ext:_______________________________**Contact Fax:** ________________________