MedStar Family Choice

5233 King Avenue, Suite 400
Baltimore, MD 21237
P 800-905-1722
F 410-933-3077
MedStarFamilyChoice.com

PROVIDER ALERT

AVOIDING MEDICATION DENIALS

Dear Participating Provider,

As previously noted, MFC must follow NCQA regulations requiring a 24-hour turnaround time for all pharmacy requests. This means that if clinical is not received with the request or within 24 hours, the request is likely to be denied and our mutual patient will not get their medication.

By following these simple steps, you can assist your patient to get the medications they need while avoiding denials and appeals that are very burdensome to you, your practice, and your patients.

- Submit complete clinical information at time of submission of request.
- Check the MedStar Family Choice Formulary and Pharmacy Prior Auth table before submitting request. Our formulary is vast!
- Only use the prior authorization forms located on our website. They are designed to guide you.
    - https://www.medstarfamilychoice.com/maryland-providers/pharmacy-prescription-information
- Please make sure the forms are filled out completely and accompanied with the clinical to support requested medication.

If you have any questions, or need assistance to locate prior authorization forms, please contact us at 410-933-2200 Ext. 2 and we will be happy to help.

Thank you,
MedStar Family Choice
Utilization Management Team

Prior Authorization/Non-Formulary Medication Request

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:** _______________________