General Prior Authorization (PA) Form

Do Not Use for Antipsychotics

Incomplete forms will not be reviewed

Maryland Medicaid
Office of Pharmacy Services
Fax: (866) 440-9345
Phone: (833) 325-0105

Date: _____

This prior authorization is for:

❑ Age override ❑ Clinical criteria ❑ Non-preferred drug ❑ Quantity limit ❑ Other: _____

To find an alternative medication that is available without prior approval, please see the MDH Preferred Drug List at: https://bit.ly/4cOVHk5
If brand is required over its generic, please complete and submit the MedWatch Form: https://bit.ly/4eQlaeO

Patient Information

Name: _____ DOB: _____ ❑ M ❑ F

Medicaid Assistance Number: _____ Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person: Name: _____ Phone: _____ Fax: _____

Prescription Information

❑ Initial PA Request ❑ Renewal PA Request

Medication: _____ Strength: _____ Quantity: _____ Refills: _____

Directions for use: _____

Diagnosis: _____

Rationale of this request: _____

To encourage the safe and appropriate use of medications while containing costs, clinical criteria have been developed for some medications. To view clinical criteria, select this link:

https://health.maryland.gov/mmcp/pap/pages/Clinical-Criteria.aspx

I attest that

❑ The requested medication is not part of a clinical trial.

❑ The benefits of the treatment outweigh the risks, and the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature_____ Date_____