Prior Authorization/Non-Formulary Medication Request

MedStar Family Choice

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:** _____