Maryland
DEPARTMENT OF HEALTH

PREAUTHORIZATION REQUEST FORM
PHYSICIAN-ADMINISTERED INJECTABLE DRUGS

Use this form only if ALL of the following apply:	☐ Drug is administered by a healthcare professional. ☐ Drug will be furnished by the provider or facility. ☐ Drug will be billed directly by the provider or facility.

SECTION I- PATIENT INFORMATION

MEDICAID NUMBER (11 DIGIT)		TELEPHONE
NAME (LAST, FIRST, MI)		ADDRESS
DOB	SEX	

SECTION II- PROVIDER INFORMATION

PAY TO PROVIDER # (9 DIGIT)	**PRESCRIBING** PROVIDER # (9 DIGIT)
NAME	NAME
ADDRESS	ADDRESS
TELEPHONE	TELEPHONE

SECTION III- PREAUTHORIZATION REQUEST INFORMATION

REQUEST DATE	DIAGNOSIS CODES: 1. 2.
REQUEST TYPE ☐ Initiation of therapy ☐ Continuation of therapy	[*If selected, provide date of initial therapy*:]

DRUG NAME	DOSE	ROUTE
FREQUENCY	Dates of Services: FROM THRU	

HCPCS CODE	REQUESTED # UNITS PER EACH DOSE	REQUESTED # TOTAL DOSES DURING PERIOD	REQUESTED # TOTAL UNITS DURING PERIOD

DEPARTMENT USE ONLY	
DATE SPAN:	
PREAUTHORIZATION #	

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SECTION IV – PREAUTHORIZATION REQUEST (CONTINUED)

Prior Therapies *(complete only for initiation of therapy):*		
DRUG	DRUG	DRUG
DATES	DATES	DATES
REASON DRUG WAS DISCONTINUED	REASON DRUG WAS DISCONTINUED	REASON DRUG WAS DISCONTINUED

Results of monitoring parameters or lab tests supporting safe initiation or continuation of therapy:		
TEST	TEST	TEST
DATE	DATE	DATE
RESULTS	RESULTS	RESULTS

SECTION V – THERAPEUTIC JUSTIFICATION

Please attach medical records and any other relevant information documenting medical necessity for the requested drug.
(Clinical criteria can be viewed online at: https://mmcp.health.maryland.gov/Pages/Preauthorization-Information.aspx)

If applicable, please provide therapeutic justification for non-preferred drugs or for prescribing outside of FDA labeling:

SECTION VI – ADDITIONAL PREAUTHORIZATION INFORMATION

LOCATION WHERE PATIENT WILL RECEIVE TREATMENT:

☐ Physician's Office ☐ Hospital Outpatient or Facility ☐ Hospital Inpatient ☐ Other: _____

IS DRUG BEING ADMINISTERED AS PART OF A CLINICAL TRIAL? ☐ NO ☐ YES

SECTION VII – PHYSICIAN ATTESTATION & CONTACT INFORMATION

I hereby attest that the information provided on this form is true, accurate and complete to the best of my knowledge.	
PROVIDER SIGNATURE	DATE

Contact information for person completing this form:		
NAME	EMAIL	PHONE

SUBMISSION INSTRUCTIONS: Fax completed form and all required attachments to: 1-410-767-6034.