MARYLAND MEDICAID PHARMACY PROGRAM
PREAUTHORIZATION FOR HIGH-COST DRUGS
INITIATION OF THERAPY

Incomplete forms will be returned- **410-767-1455 or 1-800-492-5231 Option 3** **Fax form to: 410-333-5398**

Section I. Patient Information

Patient location: ____ Home ____ Hospital___ Clinic___Office Date of Birth:_____/_____/____
Patient Name:_____ Phone #: (_____)_____-_____
Address: _____
MA ID#:_____**A copy of Patient Medical History should accompany this request.**

Section II- Drug is used for an FDA-approved indication

Name of Drug/Strength: _____Dosage frequency:_____
Is this dosage within the FDA-recommended range? □ Yes □ No – If no, explain why:_____
_____
Indications: (Use ICD-9 with short description):_____
_____
Provide results of pertinent lab tests or values confirming above diagnoses:
_____
_____
Provide justification for selecting this high-cost drug over other less expensive yet equally effective therapeutic alternatives:
_____

Section III- Drug is used off-label

Drug Name/Strength: _____Dosage frequency:_____
Is this dosage within the FDA-recommended dosage range for the approved use? □ Yes □ No- If no, explain why:
_____
List off-label indications: _____
List references supporting off-label use:_____
Drugdex Recommendation Rating:_____
Reason for drug selection:_____
_____
Prior-therapies: (Use additional blank paper if more space is needed)
Drug:_____Period used: Fr_____/____/_____. Did drug fail? □ Yes □ No
Drug:_____Period used: Fr:_____/____/_____ . Did drug fail? □ Yes □ No
List other FDA-approved alternatives that could be considered for this patient but not used:
Drug: _____ Reason for not choosing this drug: _____
Drug: _____ Reason for not choosing this drug:_____
Note: Off-label use or use of this drug at dosages other than recommended by FDA may be approved if medically necessary, safe, appropriate, and documented in and supported by one of the three official compendia (the AHFS Drug Information, the Micromedex Drugdex, and the US Pharmacopeia).
Is drug used as part of a clinical study or trial? □ No □ Yes- If yes, specify sponsoring organization/drug manufacturer
Specify purpose of study: _____

I certify that the information provided is accurate. Supporting documentation kept in the patient's medical record is available for State audits.
_____, M.D. Prescriber's Name: _____ Date: ____/___ /___
(Prescriber's signature). Tel# (_____) – _____- _____Fax# (_____) - _____ - _____
License #: _____DEA #:_____ Specialty : _____
Address:_____
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MARYLAND MEDICAID PHARMACY PROGRAM
PREAUTHORIZATION FOR HIGH-COST DRUGS
CONTINUATION OF THERAPY

Incomplete forms will be returned- 410-767-1455 or 1-800-492-5231 Option 3 Fax form to: 410-333-5398

Section I- Patient Information

Patient location: ____ Home; ____ Hospital___ Clinic___Office Date of birth:_____/_____/____
Patient Name:_____ Phone #: (_____)_____-_____
Address: _____
MA ID#:_____

Section II- Rx Information

Drug/Strength: _____Dosage frequency:_____
Date of Initial therapy: ____/_____/_____

Section III- Continuation of Therapy

Provide any applicable monitoring parameters and lab tests results to support safe continuation of therapy for this drug in this patient:
Drug level: _____Date measured:_____
Lab tests: Specify type (i.e. liver function test, blood test, etc.:
_____Test Date: _____ □ Results normal □ Results abnormal
_____ Test Date: _____ □ Results normal □ Results abnormal
_____ Test Date: _____ □ Results normal □ Results abnormal
_____ Test Date: _____ □ Results normal □ Results abnormal
_____ Test Date: _____ □ Results normal □ Results abnormal
Patient's clinical response to the drug has been: □ positive □ negative
Is medication approved for long-term use? □ Yes □ No
If drug is not indicated for long-term use, does the medical literature or official compendia support safe chronic use of the drug? □ Yes □ No
Action taken:
□ Continue same therapy for: ___ months
□ Discontinue therapy due to: ___ side-effects/adverse events
___ therapeutic failure or lack of response
___ Other reasons: _____
□ Replace drug with_____ □ Add following agent to existing therapy_____
_____
Based on an evaluation of patient's clinical conditions, lab test results and clinical data, is continuation of this high-cost therapy justified in terms of long-term safety and efficacy in this patient? □ Yes □ No
Comment on the drug's efficacy, adverse effects, or any compliance issues: _____
_____
_____

I certify that I have evaluated and monitored patient's lab test results & clinical data to ensure safe use of this drug in this patient. Supporting documentation kept in the patient's medical records is available for State audits.

_____, M.D. Prescriber's name: _____
(Prescriber's signature). Date: _____/_____ /_____
Tel# (_____) – _____- _____ Fax# (_____) - _____ - _____
License #: _____DEA #:_____ Specialty : _____
Address:_____
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