Maryland
DEPARTMENT OF HEALTH

High-Cost Drug Prior Authorization Form
Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis: _____

Prescription Information:

Medication: _____

Strength: _____

Direction_____

❑ Submit most recent progress note and pertinent lab/test results for both initial and renewal requests. Objective clinical benefits should be evident in the note for any renewal request.

Justification for selecting the high-cost drug over other less expensive yet equally effective therapeutic alternatives:

_____

_____

Is this dosage within the FDA-recommended range? ❑ Yes ❑ No

If no, explain: _____

Use of this drug at dosages other than FDA-approved dose may be approved if medically necessary, safe, appropriate, and documented in and supported by one of the three official compendia listed in COMAR10.09.03.06 (the AHFS Drug Information, the Micromedex, and the US Pharmacopeia).

I attest that

❑ Patient's lab test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that 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_____