Prior Authorization/Non-Formulary Medication Request

MedStar Family Choice

For Hepatitis C, Opioid and Synagis please click the following forms:

Hepatitis C Medication Prior Authorization Form
Opioid Prior Authorization Form
Synagis Prior Authorization Form

A request must be accompanied by MEDICAL RECORDS that support the medication. MFC-Maryland will approve, deny, or request supporting medical records within 24 HOURS of receipt of the request. If MFC does not receive the necessary medical records to make a determination, we may allow up to 14 calendar days to submit required clinical records. 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:** _____