maryland physicians care
Medicaid with a Heart

Return completed request and Medical Record documentation to:
Fax: 800-953-8856
If you have any questions, call:
Phone: 800-953-8854

MEDICAL RX COVERAGE DETERMINATION REQUEST FORM

Patient Name			Prescriber Name	
Member ID #			Prescriber NPI#	Tax ID Number
Sex (circle) **M** **F**		DOB	Office Phone	Office Fax
Height	Weight	Allergies	Servicing Provider (if applicable)	
Contact Person			Servicing Provider NPI#	

Medication, Strength, & Dose	Route of Admin.	Directions
☐ New Therapy: Date to Start: _____ ☐ Continuation: Date Began: _____		Expected Length of Therapy
Diagnosis for Medication Treatment	ICD10 Code	HCPCS/J Code
PRESCRIBER'S SIGNATURE (Required)		Date

This section must be completed. Incorrect completion may result in delays in reimbursement or provision of service.

☐ The medical benefit ("Buy and Bill"). **J-CODE:** _____ **Total Billable Units:** _____

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Rationale for Exception Request or Prior Authorization (Must attach supporting clinical notes)

☐ Alternate covered drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed MedWatch Form. **Specify:** (1) Covered drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each;

_____

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. **Specify:** (1) Anticipated significant adverse clinical outcome(s) **below**;

☐ Medical need for different dosage form and/or higher dosage; **Specify:** (1) New dosage form; (2) Dosage tried; (3) Documented medical reason

☐ Other: _____ (Explain below)

Required Explanation: