STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
DRUG/PRODUCT PRIOR AUTHORIZATION REQUEST FORM
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

1. Prescriber's Name (Last, First)	5. Member's Name (Last, First)
2. Prescriber's NPI	6. Member's ID
3. Prescriber's Phone	7. Member's Date of Birth (MMDDCCYY)
4. Prescriber's Fax	8. Pharmacy's Fax
9. Drug/Product Requested	
10. Strength 11. Quantity	12. Frequency of Dosage/Usage

Please complete only the section(s) that pertains to the type of PA being requested. Incomplete requests will be denied.

13. Brand Medically Necessary Request

☐ Allergic reaction to excipients in generic product. Provide clinical symptoms:

_____

_____

_____

_____

A completed federal MedWatch form (FDA 3500) must be submitted with this request when a reported allergic reaction to the generic product is the reason for BMN.

☐ Therapeutic failure to generic product. Explain:

_____

_____

_____

_____

Documentation must be maintained in your files in case of an audit. At a minimum, documentation must include date, drug/product and length of trial. If an audit cannot find and verify documentation, recoupment will be initiated.

14. Early Refill Request

☐ Change in Directions

Previous Directions

_____

New Directions

_____

Last Date of Fill (MM/DD/CCYY)

_____

☐ Lost /Stolen/Other

Last Date of Fill (MM/DD/CCYY)

_____

Documentation of lost, stolen or destroyed meds MUST be attached for approval.

☐ Vacation Supply

Date of Departure (MM/DD/CCYY)

_____

Date of Return (MM/DD/CCYY)

_____

15. Non-Preferred Drug/ Product Request

☐ Intolerance of the preferred agents/products. clinical symptoms:

_____

_____

_____

_____

☐ Adverse reaction to the preferred agents. Provide clinical symptoms:

_____

_____

_____

_____

☐ Inadequate response to the preferred agents/ product

☐ Absence of appropriate formulation of preferred agents/product

☐ Medically necessary

16. Optimal Dose Request

☐ Therapeutic failure to once daily dosing:

☐ Medically Necessary:

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regs. Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that the client is under my clinic's/practice's ongoing care. I understand that Prior Authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications/products, except for Early Refill Requests, which are valid one time only.

17. Signature of Prescriber* _____ 18. Date (MM/DD/CCYY)_____

* Mandatory (others may not sign for prescriber). **In accordance to mandates set forth in the Affordable Care Act (ACA), providers who order, prescribe, or refer clients for services must be enrolled in the Connecticut Medical Assistance Program (CMAP). Effective 10/1/2013, any prescriptions or services provided by a non-enrolled provider will no longer be considered/covered by CMAP.**

(Direction Sheet) Informational Only

No.	Name	Description
1.	Prescriber's Name (Last, First)	Enter the prescribing practitioner's last name and first name
2.	Prescriber's NPI	Enter the prescribing practitioner's National Provider Identification (NPI) number
3.	Prescriber's Phone	Enter the prescribing practitioner's phone number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
4.	Prescriber's Fax	Enter the prescribing practitioner's fax number where a PA customer service representative can contact the practitioner for additional information or clarification, if necessary
5.	Member's Name (Last, First)	Enter the member's name as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
6.	Member's ID	Enter the member's 9-digit identification number as it appears on the member's CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS)
7.	Member's Date of Birth (MMDDCCYY)	Enter the member's date of birth in MM/DD/CCYY format
8.	Pharmacy's Fax (optional)	Enter the pharmacy's fax number, if known
9.	Drug/Product Requested	Enter the drug/product for which the Prior Authorization is being requested (brand/generic)
10.	Strength	Enter the strength of the drug in milligrams
11.	Quantity	Enter the quantity of the drug/product being prescribed
12.	Frequency of Dosing/Usage	Enter the dosing/usage frequency
13.	Brand Medically Necessary Request	Enter the justification for the brand medically necessary request: • For allergic reaction – the prescriber must indicate the clinical symptoms of the reaction and submit a completed MedWatch form (FDA 3500) with the BMN PA request • For therapeutic failure – the prescriber must explain the number and length of trials of generic medication/product
14.	Early Refill Request	Enter the justification for the early refill request: • For change in dose – the prescriber must provide the previous frequency of dosing/ usage, as well as the new frequency of dosing/usage to justify the increased utilization • For lost/stolen/other – the prescriber must document the Last Date of Fill as well as documentation of the lost or destroyed medication/product o Appropriate written documentation for lost medication/product can be: insurance report, police report, letter from the prescriber or pharmacist on formal company letterhead explaining the extenuating circumstance, record of admittance to an institutional facility such as a hospital, record of arrest or incarceration during the time in question, etc. o Documentation for destroyed medication/product can be a fire marshal's report, insurance report, police report, or record of an institutional facility destruction of medication in the presence of a witness, etc. • For vacation supply – the prescriber must document the *date of departure* and *date of return* for the client in MM/DD/CCYY format. Only one early refill authorization will be granted for a specific medication/product for a vacation supply every six months with the authorized quantity equal to one refill.
15.	Non-Preferred Drug/Product Request	Enter the justification for the non-preferred drug/product request: • For intolerance to preferred agents/products – the prescriber must provide clinical symptoms of intolerance • For adverse reaction to preferred agents/products – the prescriber must provide clinical symptoms of adverse reaction and is asked to complete and submit a MedWatch form to the FDA (optional) • For inadequate response to preferred agents/products, absence of appropriate formulation of preferred agents, or medically necessary/medically appropriate – no further information is required • Prior authorizations will not exceed 6 months fom date of fill for controlled medications and 1 year for non-controlled medications/products.
16.	Optimal Dose Request	Enter the justification for the optimal dose request: • For therapeutic failure to once daily dosing – the prescriber must provide clinical symptoms of response to once daily dosing • For medically necessary/medically appropriate – the prescriber must provide clinical symptoms that justify medical necessity or appropriateness
17.	Signature of Prescriber	The prescribing practitioner must sign the PA form; agent's signature is not acceptable
18.	Date (MM/DD/CCYY)	Enter the date the form was completed, signed, and submitted in MM/DD/CCYY format