STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
DRUG/PRODUCT PRIOR AUTHORIZATION REQUEST FORM
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110
(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	
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. Provide documented chart notes

A completed federal MedWatch form (FDA3500) 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. Provide details of length of trial (all trials must be at least 30 days) and how therapeutic failure was determined or defined

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 - Provide specific details, notes, and chart documentation as to which preferred agents were tried, length of time used, and the nature of the intolerance including adverse effects

☐ Adverse reaction to the preferred agents - Provide specific details, notes and chart documentation as to which. preferred were agents tried, length of time used, and specific information relating to the adverse reaction

☐ Inadequate response to the preferred agents/ product - Provide specific details, notes, and chart documentation as to which preferred agents were tried, length of time used, and nature of inadequate response

☐ Absence of appropriate formulation of preferred agents/product - Provide specific details, notes, and chart documentation as to why formulation of preferred agents are not appropriate for this patient

16. Optimal Dose Request

☐ Therapeutic failure to Once Daily Dosing - Please provide dosage used, length of time and how therapeutic failure was determined or defined

☐ Dosing Greater than Once Daily is Medically Necessary - Please provide dosage and frequency used, length of time and why more than once daily dosing is 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 (Removed)	Enter the pharmacy's fax number, if known (Removed)
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	Provide 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 and how therapeutic failure was determined or defined
14.	Early Refill Request	Provide 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	Provide 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 –clinical documentation must be provided • Prior authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications/products.
16.	Optimal Dose Request	Provide 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 and how therapeutic failure was determined or defined • 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