State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
DOSE CONSOLIDATION / DRUG DOSAGE

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Drug Name	**Strength**	**Dosage Instructions**	**Quantity**	**Days Supply** (34 retail / 90 mail order)	**Refills**
_____	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Demonstration (Required)

☐ **Dose Consolidation:**
At least one criteria required (please submit supporting chart notes)

- □ Prior trial of drug on a once-every-day basis at current total daily dosage failed (describe and include approximate dates):
- □ Patient unsuitable for once every day trial due to (describe):
- □ Patient needs titration of dose, but will eventually be on once daily schedule**:**

_____

_____

☐ **Exceeding Maximum Dose:**
At least one criteria required (please submit supporting chart notes)

- □ Member is taking concomitant metabolism-inducing medication (describe):
- □ Member shown to be a rapid extensive or ultra rapid metabolizer at CYP2D6 (describe):
- □ Member was on high dose at time of transfer and records not available for rationale or has a long history of high dose usage (Will allow 2 month approval for titration to an FDA approved dose):
- □ Other Reason (describe):

_____

Clinical Literature References:

_____

_____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission:_____
***MUST MATCH PROVIDER LISTED ABOVE**