State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
SYRINGE FILLING PA

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** 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: |__|__|__|__|__|__|__|__|__|__|__|

One dispensing fee per 14 day supply.

Insulin Type	# of Units	How often
_____	_____	_____
_____	_____	_____

Medical Necessity Documentation:

Does the patient:

Y N Have visual or physical limitations that limit their ability to prepare their own syringes?

Y N Lack capable assistance residing with the patient?

If applicable, what other arrangements were tried first?

_____

_____

Length of time service is needed _____ months/year.

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**