**MADAP Preauthorization Request Form for Early Refill/Extra Medication**

MADAP provides standard coverage for prescription medications dispensed by a pharmacy in a 30-day supply for each fill. Before a refill is allowed, at least 80% of the supply of medication must be exhausted (e.g., 24 days of a 30-day supply). Under MADAP’s preauthorization policy, a client may receive an early refill or extra medication with the submission of this request form. **Please complete and fax this request form to** **(410) 333-2608 or (410) 244-8696.**

**\*Name of Case Manager, Provider or Pharmacy Staff completing this form:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| \*Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*MADAP ID#: **9 4** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_  \*Client Phone #: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*DOB: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Fax #: (\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*Phone #:** (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***If completed by MADAP Staff,******check here* □**

**\*Indicate reason and requested day supply for extra medication. *Check all that apply*:**

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| * **Lost, stolen, or damaged medication(s)** **replacement**:   14/15-day: \_\_\_\_\_ 30-day: \_\_\_\_\_   * *If client’s insurance plan denies coverage for replacement of lost, stolen or damaged medication(s), check here* **□** * *If damaged, please return medications to the pharmacy for disposal* * **Medication not taken as prescribed**:   *Specify*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * **Other reason(s) for request:**   S*pecify*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| * **I/Patient will be traveling outside the State of Maryland:** * *Please fill in the travel dates shown on your trip itinerary.* * *If by car or bus, fill in your travel dates and check here* **□**   Expected Departure Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected Return Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * **I/Patient will be re-locating outside the State of Maryland:**   Expected Departure Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * **Extra-day supply, *check one:***   60-day: \_\_\_\_\_ 90-day: \_\_\_\_\_ (100-day supply maximum)   * **Standing 90-day supply,** *reason*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*Requested medication(s):**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Pick-up date:** \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ **\*Insurance Coverage Information:**

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| Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Certification Statement:** I certify that the above information is true and correct. I understand that MADAP may not replace any authorized extra supply of medication(s) if lost or stolen. I understand that my/the patient’s medical care provider may be required to issue new prescriptions, as allowed under MADAP guidelines, to have the pharmacy fill the requested medication(s). I understand that authorization for the requested extra medication(s) may be limited by my/the patient’s current eligibility period and/or may require having additional eligibility information submitted. I understand that extra refills of DEA Schedule IV medications may require a letter of support from my/the patient’s medical care provider.

**\*Signature of Client/Requestor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Date:** \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_