



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF MEDICAID &
MEDICAL ASSISTANCE

Delaware Medical Assistance Program

**Request for Medication Prior Authorization
PDL, Quantity Limit, and Medical Necessity**

Submit request via the [DMAP Provider Portal](#) or by fax: 1-302-454-0224

The purpose of this record is for payment purposes. The member's medical record must substantiate the information provided on this form and compare for consistency. DMAP reserves the right to request chart records to confirm the information provided below.

General Information

Member Name: _____	DOB: _____
Medicaid ID Number: _____	Date of Request: _____
Practitioner Name: _____	NPI: _____
Office Phone Number: _____	Office Fax Number: _____
Diagnosis with ICD-10: _____	
Requested Medication with Strength: _____	
Proposed Directions: _____	Proposed Duration: _____
Is Brand Name Medication Medically Necessary? ☐ Yes* ☐ No *if yes, MedWatch Form 3500 is required	

Therapy Information

Must include drug, strength, dose, directions/frequency.

1. Past therapy: _____

2. Current therapy: _____

Specification of Request (Mark all that apply).

- | | |
|--|--|
| ☐ Nonpreferred Medication/PDL Override | ☐ Medical Necessity for Criteria Override |
| ☐ Early Refill or Lost/Stolen Medication | ☐ Medication Claims over \$500 |
| ☐ Duplicate Therapy | ☐ Quantity Limitation Override |
| ☐ Brand Name Request (Must include a MedWatch Form) | ☐ Part D Override Request |

Detailed Requirements

Check boxes that apply and use the space below to indicate other required information. Requests not meeting all applicable criteria will be denied.

Nonpreferred Medication/PDL Override

- ☐ Specify failure of preferred PDL medication and clinical justification for the reason to change to a nonpreferred medication.

- ☐ For members new to Medicaid, a pharmacy profile, chart notes showing previously failed preferred or previous physician contact information should be provided along with the non-preferred product request form.

Early Refill or Lost/Stolen Medication

- ☐ Document if there was a change in directions and provider change below.
- ☐ Stolen and destroyed medication request must be accompanied by a police or fire marshal report as appropriate.

Duplicate Therapy

- ☐ Request is for the tapering period which is specified in spaces below.
- ☐ Member is refractory to any one single agent and documentation is provided below or attached.

Medical Necessity for Criteria Override or Brand Name Request

- ☐ Documented allergic reaction / adverse reaction – must attach completed Med Watch Form.
- ☐ A copy of the member's record showing that other drug products within the same therapeutic class of drugs have been ruled out because previous clinical trials with that member produced ineffective or unsafe results.

Medication Claims Over \$500

- ☐ Dosage and frequency of medication is within the Food and Drug Administration (FDA) approved range.
- ☐ Appropriate preferred medications have been utilized and are documented on form and in claim history or pharmacy profile is attached.

Quantity Limitation Override

- ☐ Documentation of medical necessity along with other medications used, titrations, and reasons for not changing to a lower quantity of another medication.

Part D Override Request

- ☐ Eligibility Transaction was submitted to NDC Health
- ☐ Specify if member choose a Prescription Drug Plan for Medicare D and status of member's program.

Required Justifications

In space below, provide justifications required as specified above:
