



# Preferred Drug List Exception Request

Division of Medicaid  
State of Mississippi  
550 High Street Suite 1000  
Jackson, MS 39201

Administered by  
Health Information Designs (HID)  
Fax, Phone, Mail Completed form to:  
**Fax: 1-800-459-2135**  
Phone: 1-800-355-0486  
P.O. Box 320506  
Flowood, MS 39232

<b>Patient Name</b> (Last) (First) MI	<b>MS Medicaid 9 Digit ID #:</b>	<b>Date of Birth</b>
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<b>Practitioner Name</b> (Last) (First) (MI)	<b>NPI#</b>
	<b>Medicaid ID #</b>

<b>Practitioner Address</b> (Street) (City) (State) (Zip)	<b>Phone #</b>
	<b>Fax #</b>

<b>Pharmacy Name &amp; Address</b> (City) (State)	<b>Provider Number</b>	<b>Phone#</b>
		<b>Fax #</b>

<b>Non-Preferred Drug Requested</b>	<b>Dose</b>	<b>Directions</b>
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<b>Diagnosis</b> (Optional) Diagnosis Code (ICD-9-CM)
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**Please answer each of the following questions for your request to prescribe a non-preferred drug for your patient:\***

1. Has the patient experienced treatment failure with the preferred products(s)?  Yes  No  
1<sup>st</sup> Drug \_\_\_\_\_ Length of Therapy \_\_\_\_\_ Reason for D/C \_\_\_\_\_

2<sup>nd</sup> Drug \_\_\_\_\_ Length of Therapy \_\_\_\_\_ Reason for D/C \_\_\_\_\_  
Attach additional documentation of other treatment failures with preferred drugs if necessary.

2. Does the patient have a condition that prevents the use of the preferred products(s)?  Yes  No  
If YES, list the interaction(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred products(s)?  Yes  No  
If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)?  Yes  No  
If YES, list the side effects in the box below:

***\*MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.***

**Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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