CONTINUATION OF THERAPY
PRIOR AUTHORIZATION FOR
SPECIALTY DRUGS AND HIGH-COST DRUGS

This form must be completed in its entirety in order to be processed. Please submit request for Continuation of Therapy at least 15 days before the expiration of the current authorization. Please fax completed form and all supporting clinical documentation to 1-866-999-7736 or 1-800-583-6010. **INCOMPLETE forms and requests will be returned**. For any questions, please contact our Pharmacy Services Department at 1-800-555-8513.

☐ ***Standard*** (Standard review timeframe is **within 24 hours** for complete requests.)

☐ ***Urgent*** (Please only check this box if applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function. Please provide an explanation if the box is checked.)

Section I – Patient and Prescribing Provider Information

Member's Name: _____
First Middle I. Last

Member's ID Number: _____ Date of Birth: ____/____/____

Requesting Provider: _____ NPI: _____ DEA: _____

Contact Person at Office: _____ Phone: _____ Fax: _____

Are you a **participating provider** with Jai Medical Systems? ☐ Yes ☐ No

Section II – Medication Information

Requested Medication: _____ Date of Initial Therapy: _____
Quantity: _____ Days' Supply: _____ Duration of Therapy: _____
Relevant Diagnosis: _____ ICD-10: _____

Section III - Continuation of Therapy

Is the patient compliant with the medication as prescribed? ☐ Yes ☐ No
Has the patient experienced any adverse effects? ☐ Yes ☐ No
Patient's overall clinical response to the drug has been: ☐ Positive ☐ Negative ☐ No change
Is medication approved for long-term use? ☐ Yes ☐ No
Rationale for Continuation of Therapy:

_____
_____

Provide all applicable monitoring parameters and lab tests results to support safe continuation of therapy for this drug:

Drug level: _____ Date measured: _____
Lab tests: *Specify type (i.e. TB test)*
_____ Test Date: _____ ☐ Results normal ☐ Results abnormal
_____ Test Date: _____ ☐ Results normal ☐ Results abnormal
_____ Test Date: _____ ☐ Results normal ☐ Results abnormal

Section IV - Certification Statement

☐ I certify that I have evaluated and monitored the patient's lab test results and clinical data to ensure the continued safe use of the requested medication.
☐ I certify that the information provided on this form is complete and accurate,
☐ I certify that I have attached all relevant clinical documentation needed to support this request.
☐ I certify that I am active with the Maryland Medicaid ePREP system.

Provider Signature: _____ **Date:** _____