Medicaid Medical Pharmacy (Drug) Prior Authorizatiom Form

This form is for provider administered outpatient medications or infusions ONLY (Buy and Bill).
Fax form to **1-855-865-9469**
For questions, please call **1-800-460-8988**

□ Standard Request - Determination within 14 calendar days of receiving all necessary information.
□ Urgent Request - - I certify this request is urgent and medically necessary to treat an injury, illness, or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X______________________URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY

MEMBER INFORMATION	PRESCRIBER INFORMATION
Member ID #:	Name:
First Name:	Specialty:
Last Name:	NPI #:
Date of Birth	Group or Hospital:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Height:	Phone:
Weight:	Fax:
	Contact Name:

SERVICING PROVIDER/MEDICATION SUPPLIER (choose from the options below)

□Dispense from Pharmacy Requests (Do NOT Use This Form**) Contact Centene Pharmacy Services at 866-399-0928**
□Dispense from Office, Hospital, Outpatient Center Stock

Location Name:	
Location NPI:	
Phone: Fax:	Contact Name:

INSURANCE INFORMATION	
Primary Insurance:	Secondary Insurance:
ID Number:	ID Number:
Phone Number:	Phone Number:

DIAGNOSIS

Diagnosis Date:	Diagnosis:	ICD 10:

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION. ***NOTE: Include diagnostic clinicals (labs, radiology, etc.). For chemotherapy medication requests, include regimen and anticipated dates of service***

A. Is the member currently treated with this medication?
□YES; How long? [go to item B] □NO [skip items B & C; go to item D]

B. Is this request a continuation of a previous approval by Absolute Total Care?
□YES; [go to item C] □NO;[skip item C]

C. The strength, dosage, or quantity required per day has:
□INCREASED □DECREASED □REMAINED THE SAME

D. Indicate PREVIOUS medications treatment/outcomes below.

Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1.		
2.		

MEDICATION REQUESTED

HCPCS/J-CODE & Medication Name	Strength/ Dose	Directions	Qty/Billable Units	Requested # of visits	Start Date for Request

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