Medicaid Medical Pharmacy (Drug) Prior Authorization 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 1-866-433-6041, ext. 64455

□ **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)

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

Location Name:	
Location NPI:	
Phone:	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

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

MEDICATION REQUESTED

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

Prescriber's Signature_____ Date:_____