



# 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:			
<b>SERVICING PROVIDER/MEDICATION SUPPLIER (choose from the options below)</b>					
<input type="checkbox"/> Pharmacy Benefit Requests-Dispense from Pharmacy (Do NOT Use This Form) Call Pharmacy Services at 866-399-0928					
<input type="checkbox"/> Dispense from Office, Hospital, Outpatient Center Stock <input type="checkbox"/> Other					
Location Name:					
Location NPI:					
Phone:			Contact Name:		
<b>INSURANCE INFORMATION</b>					
Primary Insurance:			Secondary Insurance:		
ID Number:			ID Number:		
Phone Number:			Phone Number:		
<b>DIAGNOSIS</b>					
Diagnosis Date:		Diagnosis:		ICD 10:	
<b>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.</b>					
A. Is the member currently treated with this medication?					
<input type="checkbox"/> YES; How long? _____ [go to item B] <input type="checkbox"/> NO					
B. Is this request a continuation of a previous approval by Absolute Total Care?					
<input type="checkbox"/> YES; [go to item C] <input type="checkbox"/> NO; [skip item C]					
C. The strength, dosage, or quantity required per day has:					
<input type="checkbox"/> INCREASED <input type="checkbox"/> DECREASED <input type="checkbox"/> REMAINED THE SAME					
<b>MEDICATION REQUESTED</b>					
HCPCS/J-CODE & Medication Name	Strength/Dose	Directions	Qty/Billable Units	Requested # of visits	Start Date for Request

Prescriber's Signature \_\_\_\_\_ Date: \_\_\_\_\_

CONFIDENTIALITY NOTICE: This facsimile transmission was intended solely for the individual to whom it is addressed. The information contained in this transmission is protected by the Personal Privacy Protection Law or is otherwise privileged. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivery to the intended recipient, please be advised that any dissemination, distribution or copying of this message is strictly prohibited. If you have received this communication in error, please contact the sender immediately to arrange for the return or other disposition of the transmission.