Drug Prior Authorization Request form

Patient Information:

Name: _____

DOB: _____

Nine-Digit HFS Recipient #: _____

Height/Weight_____

Does the patient have any allergies? _____

Provider Information:

Name: _____

Prescriber specialty: _____

Phone Number: _____

NPI #: _____

Medication: _____ Strength: _____

Quantity: _____ Refills: _____

Is this a renewal request? Yes__ No____. If so, when was treatment with the requested medication started? _____

Please list all medications previously tried for this indication and description of failure (e.g. side effect, intolerance, etc.: _____

_____

_____

_____

Please list all reasons for selecting the requested medications, dosing schedule and quantity over alternatives that do not require prior authorization:

_____

_____

Please list other medications the patient will use in combination with the requested medication for treatment of this diagnosis: _____

_____

Has the patient had clinical stabilization or improvement from the baseline? Yes____ No____.

Will any current drugs for this diagnosis be discontinued if this drug is approved? If so, please list below: _____

Is patient being discharged from hospital or institution on this medication? Yes__ No__.

Any other pertinent information? _____