Arizona Medicaid Prior Authorization / Exception Request Form

FAX: (877) 422-8130
Phone: (800) 322-8670

To ensure a timely response, please fill out the form completely and legibly.

☐ **Standard (Up to 14 Calendar Days)**
☐ ***Expedited*** **(Up to 72 hours)**

Member Name Last, First)	Member ID#	DOB	Date
Requesting Provider Name	NPI:	PCP (if different)	
Office Contact Person	Direct Phone #	Fax #	
Diagnosis 1 (include ICD-9)	Diagnosis 2	Diagnosis 3	

Please send all pertinent clinical documentation with this fax.

Use of pharmaceutical samples cannot be accepted as justification.

Name of Medication	Dosage	Quantity/ Amount	Refills (<12)
Sig/Instructions	Allergies		
List Formulary Medications Tried include length of treatment and response with dates			
List Formulary Medications Contraindicated / Reason			

☐ This is a reauthorization of current medication. Recent clinical documentation is required. Please provide.