

## 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.**

<input type="checkbox"/>	<b>Standard (Up to 14 Calendar Days)</b>
<input type="checkbox"/>	<b><i>Expedited*</i> (Up to 72 hours)</b>

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.

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