Print Form Reset Form

FLORIDA MEDICAID

Prior Authorization

Pharmacy – Miscellaneous

Maximum length of approval = 12 months or less

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number -

Prescriber Fax Number -

Drug: _____ **Quantity:** _____ **Dosage and Frequency of Dosing:** _____

Diagnosis: _____

Previous Therapy (include drug, dose, and duration):

1. _____ Date of trial:_____
2. _____ Date of trial:_____
3. _____ Date of trial:_____

Reason for Discontinuing Previous Therapy:

Allergic reaction **(please specify and submit progress notes to support):** _____

_____

Contraindication(s) (list conditions):_____

Drug interaction(s) (please specify): _____

Therapeutic Failure **(please provide lab data, discharge summaries, or progress notes):** _____

_____

Medical records supporting requested therapy over other preferred medications listed on the Florida Medicaid Preferred Drug List are required. This list may be found at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/.

Prescriber's Signature _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.