INDIANA
MEDICAID Rx PRIOR AUTHORIZATION REQUEST FORM

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	

III. MEDICATION REQUESTED (<u>one medication request per form</u>)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	

IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		***NOTE: Include diagnostic clinicals (labs, radiology, etc.).***	

V. MEDICATION HISTORY (<u>for this diagnosis</u>)

A. Is the member currently on this medication? ☐**Yes**; how long? _____ ☐**No**; skip to items B&C, go to **D**.

B. Is this a request for continuation of a previous approval? ☐**Yes**; go to item **C**. ☐**No**; skip item C, go to **D**.

C. Has the strength, dosage, or quantity required per day: ☐**INCREASED** ☐**DECREASED** ☐Remained the **SAME**

D. Indicate PREVIOUS medications treatment/outcomes below. ***NOTE: Confirmation will be made using claims history.***

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.

☐ Medical intolerance to the preferred drug. Provide clinical symptoms.
☐ Inadequate response to the preferred drug.
☐ Absence of appropriate formulation or indication of the drug. Please specify.
☐ Other – Provide rationale for the request.

Prescriber Signature – **Dispense as Written (DAW)**:

X_____ Date: _____

Prescriber Signature – **Substitution Permitted**:

X_____ Date: _____

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