Medicaid Prior Authorization Request MICHIGAN

Instructions:

- 1. Only 1 medication per form
- 2. All fields must be completed and legible for review

Date of Request:								
Patient Information			Pres	Prescriber Information				
Patient Name:			Prescriber Name	Prescriber Name and Specialty:				
Member ID #:			NPI #:	NPI #:				
Sex: ☐ Male ☐ Female			Office Phone:	Office Phone:				
Date of Birth:			Office Fax:	Office Fax:				
Patient Phone:			Contact Person:	Contact Person:				
Diagnosis and Medical Information								
Medication:		Strength & Route of		of Administration:	dministration: Frequer		icy:	
Height & Weight:		Expected Length of T		of Therapy:	Qı	Quantity:		
BMI:	Date Calculated:		Blood Pressure:		<u>l</u>	Taken On:		
Diagnosis Related to Medication Request:								
Drug Allergies:								
Rationale for Prior Authorization History of a medical condition, allergies or other pertinent information requiring the use of this medication:								
Previous use of non-authorized and prior authorized medications tried and failed for this condition: Name of Medication Reason for Failure Date of Failure								
You must include the most recent relative laboratory results to ensure a complete PA review.								
Prescriber's Signature:					Date:			

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