Pennsylvania Medicaid

PRIOR AUTHORIZATION REQUEST FORM

Non-formulary drug

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. What is the requested duration of therapy?

Q2. Has the patient been treated previously with the medication?
☐ Yes ☐ No

Q3. Has the patient received samples of the medication?
☐ Yes ☐ No

Q4. Is a sample log attached including dates, dosage, and directions?
☐ Yes ☐ No

Q5. Has the patient been treated on this medication while in the hospital or a facility?
☐ Yes ☐ No

Q6. Has the patient received the medication through other means other than the above (such as through another insurer)?
☐ Yes ☐ No

Q7. Are medical records attached showing this medication being filled including dates, dosage, and directions?
☐ Yes ☐ No

Q8. Is the medication being used for a FDA approved indication?
☐ Yes ☐ No

Q9. What is the diagnosis? (Must attach the diagnosis)

Pennsylvania Medicaid
PRIOR AUTHORIZATION REQUEST FORM

Non-formulary drug

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q10. Has the patient tried and failed all formulary alternatives? ☐ Yes ☐ No
Q11. List all medications patient has been treated with previously that have resulted in failure or patient intolerance (for each please state the adverse outcome or type of failure).
Q12. Are the formulary alternatives that the patient tried and failed listed above? ☐ Yes ☐ No
Q13. Are relevant labs or diagnostic test results attached? ☐ Yes ☐ No
Q14. Additional Comments:

Prescriber Signature

Date

Made Fillable by eForms