



Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
Hewlett Packard Enterprise ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

REQUEST FOR A NON-PREFERRED DRUG

DATE: _____

CLIENT NAME: _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI/DEA #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER: () _____

REQUESTER NAME: _____ RN/MD/RPH: _____

PHONE NUMBER: () _____ FAX NUMBER: () _____

DRUG REQUESTED: _____ QTY / FILL: _____

DIAGNOSIS, ICD-10 CODE: _____

PREFERRED MEDICATION IN THE SAME CLASS THE PATIENT HAS TRIED: _____

WHAT WAS THE OUTCOME? _____

IF YOU ARE REQUESTING A BRAND NAME DRUG, PROVIDE THE DATES THAT THE GENERIC WAS TRIED AND THE OUTCOME:

EXPLAIN WHY THIS PARTICULAR NON PREFERRED MEDICATION IS MEDICALLY NEEDED FOR THIS PATIENT:

PRESCRIBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

RI Medicaid FFS PRIOR AUTHORIZATION FAX NUMBER 1-401-784-3889
CONTACT HEWLETT PACKARD ENTERPRISE CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: _____ YES _____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____