Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

FAX completed form to **1-866-964-3472**

MAIL: Goold Health Systems, an Emdeon company
P.O. Box 21719
Cheyenne, WY 82003

PHONE: 1-877-207-1126
(For questions or inquiries ONLY)

Provider must fill in ALL information below. It must be legible, correct and complete or form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

****To request a client's Control Substance (II-IV) profile, including carisoprodol (Soma) and tramadol (Ultram), contact the Wyoming Board of Pharmacy Prescription Drug Monitoring Program at 307-634-9636 or http://pharmacyboard.state.wy.us.**

Drug Name (Only 1 Drug per Form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

1. Is this only a dose or quantity change from a previously approved PA? ☐ **Yes** ☐ **No**
2. Can the previously approved PA be cancelled? ☐ **Yes** ☐ **No**

Medical Necessity Documentation Required: (Attach copies of supporting documentation.)

3. Client's Medical Diagnosis_____

4. Why is this medication necessary for this client?_____

_____

5. What other "preferred" alternatives (**including samples**) have been tried and why they were discontinued? Please include the dates of each trial or explain why the dates are unknown. Please provide as much information as possible. (The Preferred Drug List (PDL) is available at www.wymedicaid.org).

	Medication	**Dates of use**	**Reason for Discontinuing**
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
F.	_____	_____	_____

6. Explain why each untried "preferred" alternative is unsuitable or less desirable: _____

_____

7. **Prescriber Signature: _____ Date of Submission: _____**
MUST MATCH PRESCRIBER LISTED ABOVE

Made fillable by eForms