Prior Authorization (Medication) Request

Date: ___________________________

(*Please check one*)

☐ **MFC - Maryland Fax: (410) 933-2274**
☐ **MFC - DC Healthy Families/ Alliance Fax: (202) 243-5495**

Member Name: (*Please print*) _________________________________DOB: _____________

Member MedStar Family Choice ID #: _____________________ **Medicaid ID #:** ______________
(*MD ID begins with **91**…; DC ID begins with **61**…)*

Provider Name/Office: _________________________________ **NPI#**____________________________

Provider Phone: _____________________________ **Provider Fax:** _____________________________

Contact Person Name: ____

Contact Phone w/ext: ______________________________ **Contact Fax:** ______________________
(If different from above)

Medication Requested (*Dose and Frequency*):____

****Is the member currently on this medication:** ☐ **Yes** ☐ **No**

Include Previous Medications: ____

☐ **Vacation** ☐ **Lost Medication** ☐ **MD Increased Dose/Frequency** ☐ **Medication Stolen**

*****Please consult the MedStar Family Choice formulary before submitting for prior authorization*****

Diagnosis Code(s) /ICD-10:____

Pharmacy Name: ______________________________________ **Phone:** ______________________

*****Please provide all clinical notes to support the request and fax to the number above*****

☐ **Approved** ☐ **Denied** **MFC Reviewer:** ____________________________________