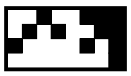
District of Columbia Pharmacy Program

DC Pharmacy Services PA



21381

Request Date ☐☐ / ☐☐ / ☐☐☐☐

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber DEA # ☐☐ - ☐☐☐☐☐☐☐

Prescriber NPI # ☐☐ - ☐☐☐☐☐☐☐☐☐☐

Person Completing Form _____

Pharmacy Name: _____ **Pharmacy Phone#** _____

Drug Requested: (Use one form per drug)

Strength _____ **Quantity** _____ **Directions** _____

Type PA

○ **Non-PDL PA** ○ **Narcotic PA** ○ **Brand Necessary** ○ **Injectable PA** ○ **Exceed Qty Limit** ○ **Other**

Requested start date of Medication: ☐☐ / ☐☐ / ☐☐☐☐

Expected Duration of Therapy. _____

1. **Diagnosis for use of this medication?** _____
2. **Can a preferred medication be used by this patient?** ○ **Yes** ○ **No** **(If no, skip #3 and state reason below)**
3. **Can the current drug or agent be used within DC Medicaid criteria?** ○ **Yes** ○ **No** **(If no state reason below)**

Reason for use of requested drug or agent needed for prior approval

_____

_____

_____

Authorized Prescriber Signature (REQUIRED)

Date ☐☐ / ☐☐ / ☐☐☐☐

Signature of Prescriber _____

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

FAX TO: District of Columbia Pharmacy Program
Fax: 866-535-7622
PA HELPDESK: 800-273-4962

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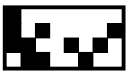

Revised - October 15, 2009