

District of Columbia Pharmacy Program
DC Pharmacy Services PA



21381

Request Date

Request Date form with boxes for month, day, and year.

Patient's Medicaid ID Number

PATIENT INFORMATION

Patient's Date of Birth

Patient's Medicaid ID Number form with boxes for each digit.

Patient's Date of Birth form with boxes for month, day, and year.

Patient's Full Name

Patient's Full Name form with boxes for each letter and space.

Prescriber's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name form with boxes for each letter and space.

Prescriber Phone:

Prescriber Phone form with boxes for area code, number, and extension.

Prescriber Fax:

Prescriber Fax form with boxes for area code, number, and extension.

Prescriber DEA #

Prescriber DEA # form with boxes for each digit.

Prescriber NPI #

Prescriber NPI # form with boxes for each digit.

Person Completing Form

Pharmacy Name:

Pharmacy Phone#

Drug Requested: (Use one form per drug)

Drug Requested form with boxes for drug name.

Strength

Quantity

Directions

Type PA

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

Requested start date of Medication:

Requested start date of Medication form with boxes for month, day, and year.

Expected Duration of Therapy.

- 1. Diagnosis for use of this medication?
2. Can a preferred medication be used by this patient?
3. Can the current drug or agent be used within DC Medicaid criteria?

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

Reason for use of requested drug or agent needed for prior approval form with lines for text.

Authorized Prescriber Signature (REQUIRED)

Date

Signature of Prescriber

Date form with boxes for month, day, and year.

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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