21381

District of Columbia Pharmacy Program

# Request for Rx Prior Authorization
# Preferred Drug Program

**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** _____

**Requested start date of Medication:** _____

**1. Diagnosis for use of this medication?** _____

**2. Can a preferred medication be used by this patient? ○ Yes ○ No (If no please state reason below):**

**Reason for use of Non-Preferred drug or agent requiring 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 - May 22, 2008