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

PATIENT INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER:

_____ – _____ – _____

PRESCRIBER FAX NUMBER:

_____ – _____ – _____

PRESCRIBER DEA #:

_____ – _____

PRESCRIBER NPI #:

_____ – _____

PERSON COMPLETING FORM
_____

PHARMACY NAME
_____

PHARMACY PHONE#
_____

DRUG REQUESTED: (USE ONE FORM PER DRUG)

Strength _____ Quantity _____ Directions _____

REQUESTED START OF MEDICATION

_____ / _____ / _____

1. **Diagnosis for use of this medication?** ☐ Yes ☐ No

2. **Can a preferred medication be used by this patient?** ☐ Yes ☐ No ☐ Yes ☐ No

   (If no please state reason below):

   Reason for use of Non-Preferred drug or agent requiring prior approval: ☐ Yes ☐ No

   _____

   _____

   _____

   _____

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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

DHCF
The Department of Health Care Finance
INVESTING IN YOUR HEALTH