

District of Columbia Pharmacy Program

Request for Rx Prior Authorization

Preferred Drug Program

REQUEST DATE: / /

PATIENT INFORMATION

PATIENTS MEDICAID I D NUMBER

[illegible]

PATIENTS DATE OF BI RTH

--	--

 /

--	--

 /

--	--	--	--

PATIENTS FULL NAME

[illegible]

PATIENT INFORMATION

PRESCRIBERS FULL NAME

[illegible]**PRESCRIBER PHONE NUMBER:**

--	--	--

-

--	--	--

-

--	--	--	--

PRESCRIBER FAX NUMBER:

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

PRESCRIBER DEA #:

		-							
--	--	---	--	--	--	--	--	--	--

PRESCRIBER NPI #:

		-								
--	--	---	--	--	--	--	--	--	--	--

PERSON COMPLETING FORM

PHARMACY NAME

PHARMACY PHONE#

DRUG REQUESTED: (USE ONE FORM PER DRUG)[illegible]

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.