District of Columbia Pharmacy Program Travel Medication/Supply

Prior Authorization Request Form

Please Fax this Request Form To 1-866-535-7622. All Information Must be Complete and Legible.

BENEFICIARY INFORMATION

BENEFICIARY'S MEDICAID ID NUMBER

BENEFICIARY'S DATE OF BIRTH ___ / ___ / ____

BENEFICIARY'S FULL NAME

MEDICATION SUPPLY REQUESTED

	Medication	Quantity	Number of Days
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			

By signing this form, I attest to the fact that the beneficiary indicated above is in regular medical care, has scheduled medical appointment with his/her doctor after returning to the District.

CASE MANAGER NAME: _____ **SIGNATURE**: _____

DATE: _____ **AGENCY:** _____

PHONE NUMBER: _____

N.B.

- The prior authorization request should be submitted 7 days prior to intended day of travel
- This prior authorization request applies to fee-for-service Medicaid beneficiaries and DC Healthcare Alliance beneficiaries who intend to travel for greater than one month.
- The prior authorization request form can be filled out by beneficiary's case manager in consultation with beneficiary's doctor.
- The following documents should accompany this prior authorization form:
  - A copy of prescription for the medication requested
  - A copy of the round trip travel itinerary
  - A letter from the provider to justify the request
- A maximum of one 90 day supply will be authorized per year. However, any exceptional requests for unforeseen circumstances will be reviewed case by case.

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