

**District of Columbia Pharmacy Program****DC Pharmacy Services Prior Authorization Request**

Request Date: _____

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____ Middle Initial: _____

Member Medicaid ID: _____

Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____

Prescriber Fax: _____

Prescriber DEA Number: _____

Prescriber NPI Number: _____

Person Completing Form: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Prescriber Phone: _____

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

Drug Requested: _____

Strength: _____

Quantity: _____

Directions: _____

Type PA:

☐ Non PDL PA	☐ Narcotic PA	☐ Brand Necessary	☐ Injectable PA
☐ Exceed Qty Limit	☐ Other		

Requested Start Date of Medication: _____

Expected Duration of Therapy: _____

Member's Name (Last, First): _____

1. What is the diagnosis for use of this medication?

2. Can a preferred medication be used by this member?

☐ Yes ☐ No

If no, skip #3 and state the reason below.

3. Can the current drug or agent be used within DC Medicaid criteria?

☐ Yes ☐ No

If no, state the reason below.

What is the reason for use of requested drug or agent needed for prior approval?

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

Prescriber's Signature: _____ **Date:** _____

Please fax this form to:

District of Columbia Pharmacy Program

Fax: 866-535-7622

Phone: 800-273-4962