Government of District of Columbia Department of Health Care Finance

Alliance Program General Prior Authorization Request Form

REQUEST DATE: _____

PATIENT INFORMATION

PATIENT MEDICAID ID: _____ **DATE OF BIRTH:** _____

PATIENT LAST NAME: _____

PATIENT FIRST NAME: _____ **MIDDLE INITIAL:** _____

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME: _____

PRESCRIBER FIRST NAME: _____

PRESCRIBER PHONE: _____ **PRESCRIBER FAX:** _____

PRESCRIBER DEA NUMBER: _____ **PRESCRIBER NPI NUMBER:** _____

PHYSICIAN SPECIALTY: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: _____ **PHARMACY FAX:** _____

PHARMACY NPI NUMBER: _____

Refer to FDA www.fda.gov for prescribing details and approved indications. https://www.accessdata.fda.gov/scripts/cder/daf/

ALLIANCE PROGRAM EFFECTIVE 10/1/2025

Alliance Program effective 10/1/20205 will be covered as a Fee for Service benefit. Coverage is limited to generic medications only.

Brand name only medications will require PA (drugs with no generic commercially available)

Over the Counter (OTC) medications not covered (Beneficiaries will need to purchase OTC medications out of pocket)

Alliance PRIOR AUTHORIZATION CRITERIA Brand medication with no generic

- Drug name and strength requested:
- Diagnosis and/or indication:
- Has the member tried other medications to treat this diagnosis above? If yes, provide supporting documentation.

LENGTH OF AUTHORIZATION CRITERIA

Length of authorization: **up to 6 months**

PRIOR AUTHORIZATION RENEWAL

- Member has met and continues to meet the initial review criteria. ☐ Yes ☐ No
- Is dosing appropriate as per labeling or supported by compendia? ☐ Yes ☐ No

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

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