Medicaid Medical Drug Authorization Form

Fax completed form to: 877-974-4411 toll free, or 616-942-8206

☐ Standard Review ☐ Urgent Review (life threatening)

Patient Information

Last Name: _____ First Name: _____

10-Digit Medicaid ID #: _____ DOB: _____

Weight: _____ ☐ **kg** ☐ **lbs** Height: _____ ☐ **in** ☐ **cm** Gender assigned at birth: ☐ **Female** ☐ **Male**

Prescriber Information

Prescriber Name: _____

Prescriber Phone: (_____) _____ Prescriber Fax: (_____) _____

Prescriber Address: _____

Prescriber NPI: _____ Prescriber Specialty: _____

Office Contact Name: _____ Office Contact Phone: (_____) _____

Product Information

Drug name: _____ Requested dose: _____

HCPCS code: _____ Requested frequency: _____

Billing Information

Administration:

☐ Office
Provider: _____ NPI: _____ Fax: _____

☐ Outpatient Infusion Center
Facility: _____ NPI: _____ Fax: _____

☐ Home Infusion
Agency: _____ NPI: _____ Fax: _____

Drug Billing:

☐ Provider to buy and bill
☐ Facility to buy and bill
☐ Home Infusion agency to buy and bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Code:

Primary: _____

Secondary: _____

Tertiary: _____

Billing Notes:

- Billing provider must be actively enrolled in the State of Michigan CHAMPS system for every date of service billed.
- Billing provider must be in-network with Priority Health Medicaid on every date of service billed.
- Drug NDC used must be included on the claim
- Drug NDC must be included in the Medicaid Drug Rebate Program (MDRP) on the date of service billed.

All fields must be complete and legible for review. Prescriber's office will receive a response via fax. Last reviewed 11/2024

Clinical Documentation

A. This request is for:

- ☐ New therapy
- ☐ Continuation of therapy

When did the patient first start using this medication? _____

What was the date of the last dose? _____

When is the next dose due? _____

B. What diagnosis is this drug being requested for? _____

C. What medications has the patient previously used for this condition?

Drug	Dose	Dates	Clinical Outcome

D. Supporting Information:

_____

_____

_____

_____

_____

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