Medicaid Pharmacy 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

Product Name: _____ Requested dose: _____

Product Strength: _____ Requested frequency: _____

Clinical Documentation

A. This request is for:

☐ New therapy

☐ Continuation of therapy

When did the patient first start using this medication? _____

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:

_____

_____

_____

_____

_____

All fields must be complete and legible. Prescriber will receive a response via fax.

Last reviewed 11/2024