

FAX TO : 1-800-459-2135

Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

Brand-Name Multi-Source Drug PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____

NPI #: _____

Medicaid ID # _____

City _____ State _____

Phone #: _____

FAX #: _____

Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____

Provider # _____

City _____ State _____

Phone #: _____

FAX #: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____

Quantity /Month _____

Daily dose: _____

NDC#: _____

Diagnosis: _____

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product: _____

Manufacturer: _____

Length of therapy _____

Observed adverse reaction or allergic reaction: _____

Documentation Included: Y N

MedWatch Form Attached: Y N

*MedWatch Form can be found at <http://www.fda.gov/medwatch/safety/3500.pdf>

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____

Denied/Code: _____

From Date _____ Thru Date _____

Reviewed by _____

HID# _____ PA# _____