57586

FLORIDA MEDICAID

Prior Authorization

Pharmacy - Miscellaneous

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___ - ____

Pharmacy Fax ___ - ____

Drug:_____ Quantity:_____ Dosage and frequency of dosing:_____

Diagnosis_____

Previous Therapy (include drug/dose/duration):_____

Medical rationale for NON-PDL request:_____

_____

_____ ○ Documents Attached

Pertinent Lab Data:_____ Other pertinent information:_____

Possible drug interactions/conflicting drug therapies:_____

Prescriber's Signature:_____ Date:_____

Please attach a copy of the original prescription.

Please attach lab results and other medical documentation to support request.

The provider must retain copies of all documentation for five years.

Fax or mail completed form to:

Affiliated Computer Services (ACS)
Medicaid Pharmacy Services
365 Northridge Rd. Suite 400
Atlanta, GA 30350
Phone: (877) 553-7481 (For Information only)
Fax: (877) 614-1078 (toll free)

For AHCA USE ONLY

Date: _____ **Notified:** _____

Approved: _____ **Start Date:** _____ **Expiration Date:** _____

Denied: _____ **Reason:** _____

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