37663

Maryland Pharmacy Program

Request for Rx Prior Authorization
Preferred Drug Program

Request Date ___ / ___ / ____

PATIENT INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth ___ / ___ / ____

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber DEA # -

Person Completing Form _____

Drug Requested: (Use one form per drug)

Check if generic is not acceptable ○ (Prescriber must complete DHMH Medwatch Form)

Strength	Dosage Form	Quantity	Directions

1. Diagnosis for use of this medication? _____

2. Why have you chosen not to use a drug from the Maryland Pharmacy Program - Preferred Drug List?

○ Inadequate response to alternatives ○ Allergy to alternates ○ Adverse event with alternatives

Select all that apply

○ Other (describe) _____

The Preferred Drug List allows the State to provide recipients quality drugs that are safe and cost-effective.

Signature of Prescriber _____ Date ___ / ___ / ____

FAX TO: **Maryland Pharmacy Program**

Fax: (866) 490 - 1901

PA HELPDESK: (800) 932-3918

Hours: Monday - Friday 8:30 am- 4:30 pm EST

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Revised - January 1, 2007