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 to use a drug that is not a preferred drug nor a recommended Tier 1 drug?

○ **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.
Current list of non-preferred drugs requiring PA is available at
http://providersynergies.com/services/documents/MDM_PDL.pdf

Signature of Prescriber _____ **Date** ☐☐ / ☐☐ / ☐☐☐☐

FAX TO: Maryland Pharmacy Program
Fax: (866) 440 - 9345
PA HELPDESK: (800)932-3918

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