MICHIGAN
Department Of Community Health Pharmacy Program
Prior Authorization Request

All information on this form must be addressed. Incomplete forms will be returned once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once, will receive a denial and will not qualify for MDCH physician review until completed.

Prescribing Physician:

Name: _____
First Last

Phone #: ___-___-____

Fax #: ___-___-____

NPI: ____________

NPI accepted as of April 17, 2007

Beneficiary: ☐ Male ☐ Female

Name: _____
First Last

Medicaid #: ____________

Date of Birth: __-__-____

Specialty: _____

Person completing form: _____ **Rqstd start date:** _____
Name Title Date

Pharmacy: _____ **Phone #:** ___-___-____

Drug Name	Strength	Dose	Duration of Rx

Diagnosis for use of this medication: _____

Can this beneficiary use a preferred medication? ☐ Yes ☐ No **If "No", give reason below:**

_____

Has the beneficiary seen any other provider for this condition? ☐ Yes ☐ No **If "Yes", what was the provider's specialty and recommendation?**

_____

Reason for the exception request: Previous history of a medical condition, allergies, lab or test results, and/or other pertinent medical information. _____

_____

Names of previous medications tried for this condition: Please include the reasons for therapeutic failure.
Drug Name / Strength / Directions: Date(s): Reason for Failure:

_____

_____

_____

Pertinent laboratory test(s) or procedure(s): (if applicable)
Procedure: Findings: Date:

_____

Additional comments: _____

_____

Submit requests to: **First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060**
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at www.michigan.fhsc.com -> Providers -> Forms

Revised 10-12-07