



**PA05 - FOLLICLE STIMULANTS**  
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services  
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)  
Gainwell Technologies ATTN: PHARMACIST  
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ MEDICAID ID NUMBER: \_\_\_\_\_

PRESCRIBER NAME: \_\_\_\_\_ PRESCRIBER NPI #: \_\_\_\_\_

PRESCRIBER OFFICE ADDRESS: \_\_\_\_\_

OFFICE PHONE NUMBER (     ) \_\_\_\_\_ FAX NUMBER (     ) \_\_\_\_\_

DRUG REQUESTED: \_\_\_\_\_ QTY / FILL \_\_\_\_\_

**INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-10 CODE.**

\_\_\_ DOES THE PATIENT HAVE A DIAGNOSIS OF HYPOGONADISM? ICD10 CODE \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.**

**CONTACT GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100**

FOR STATE USE ONLY:

APPROVAL: \_\_\_\_ YES \_\_\_\_ NO    PRIOR AUTHORIZATION #: \_\_\_\_\_

EFFECTIVE DATES: FROM: \_\_\_\_\_ TO \_\_\_\_\_