PA09 – BOTULINUM TOXINS

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

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.

___ INDICATE RELEVANT DIAGNOSIS?

_____ ICD10 CODE _____

___ IS THE PATIENT RECEIVING MEDICATION THROUGH PRESCRIBER? (Y/N)

IF YES, WHAT THE **J** CODE? J CODE_____

___ IS THE PATIENT RECEIVING MEDICATION AT THE PHARMACY? (Y/N)

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 _____

Revised 10.2020