



PA20 PRADAXA REQUEST
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 ATRIAL FIBRILLATION? ICD10 CODE _____

PREFERRED AGENTS TRIED: _____

PRESCRIBER SIGNATURE _____ DATE _____

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

RI Medicaid FFS PRIOR AUTHORIZATION FAX NUMBER 1-401-784-3889
CONTACT GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: ____ YES ____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____