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

REQUEST FOR A NON-PREFERRED DRUG

DATE: _____

CLIENT NAME: _____ DOB:_____ MEDICAID ID NUMBER:_____

PRESCRIBER NAME: _____PRESCRIBER NPI/DEA #:_____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER: ( ) _____

REQUESTER NAME: _____ RN/MD/RPH:_____

PHONE NUMBER: ( ) _____ FAX NUMBER: ( ) _____

DRUG REQUESTED: _____QTY / FILL: _____

DIAGNOSIS, ICD-10 CODE: _____

PREFERRED MEDICATION IN THE **SAME CLASS** THE PATIENT HAS TRIED:_____

WHAT WAS THE OUTCOME? _____

IF YOU ARE REQUESTING A BRAND NAME DRUG, PROVIDE THE DATES THAT THE GENERIC WAS TRIED AND THE OUTCOME:

_____

_____

EXPLAIN WHY THIS PARTICULAR NON PREFERRED MEDICATION IS MEDICALLY NEEDED FOR THIS PATIENT:

_____

_____

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 HEWLETT PACKARD ENTERPRISE CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:
APPROVAL: _____YES _____NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____TO _____

Revised 11.2015