Executive Office of Health & Human Services
MEDICAID FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM
Gainwell Technologies ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor ▪ Warwick, RI 02886 ▪ FAX (401) 784-3889 ▪ PH (401) 784-8100

PA REQUESTS LACKING ALL REQUIRED INFORMATION LISTED BELOW WILL BE DENIED.

PATIENT NAME: ____ DOB: _____________ MEDICAID ID NUMBER: ___________________________

PRESCRIBER NAME: ____ NPI #: _______________________________________

PRESCRIBER'S OFFICE PHONE NUMBER: ( ) ______________________ **PRESCRIBER'S OFFICE FAX NUMBER:** ( ) _______________________

MEDICATION REQUESTED:

MEDICATION: ____ STRENGTH: ___________________________________

DAILY DOSE REQUESTED: ____ DURATION OF TREATMENT: _______________ DAYS ___ WEEKS ___

CLINICAL INFORMATION.

1. DIAGNOSIS/ICD 10 CODE(S) SPECIFIC TO REQUESTED MEDICATION: ____

   ____

2. WHAT IS THE INITIAL DATE OF DIAGNOSIS RELEVANT TO THE REQUESTED MEDICATION? _________ /________ /_________

3. MEDICATION HISTORY: LIST MEDICATIONS USED TO TREAT DIAGNOSIS INCLUDE FEE-FOR-SERVICE PREFERRED AGENTS. LIST OF PREFERRED AGENTS CAN BE FOUND AT https://eohhs.ri.gov/providers-partners/provider-directories/pharmacy.

	PREFERRED / NON-PREFERRED DRUG TRIED	DAILY DOSE	START DATE	END DATE	OUTCOME OR WHY DISCONTINUED?
1			/ /	/ /	
2			/ /	/ /	
3			/ /	/ /	

4. **DESCRIBE WHY NON-PREFERRED AGENT IS NECESSARY:**

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   ____

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PRESCRIBER SIGNATURE ____ **DATE** ___________________

BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION BY RI MEDICAID AND THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

FOR STATE USE ONLY:

APPROVAL: ______ YES _____NO PRIOR AUTHORIZATION #: __________________________ EFFECTIVE DATES: FROM: ____________ TO ___________________