



**PA18 - MEGACE ES**  
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 AIDS WASTING SYNDROME? ICD10 CODE \_\_\_\_\_

\_\_\_ DOES THE PATIENT HAVE A DIAGNOSIS OF CANCER? 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 \_\_\_\_\_