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

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

PRESCRIBER NAME: ____ NPI #: ______________________________________

OFFICE PHONE NUMBER: ( ) __________________________________ OFFICE **FAX** NUMBER: ( ) ________________________________

MEDICATION REQUESTED:

MEDICATION: ____ STRENGTH: __________________________________

DAILY DOSE REQUESTED: ____ DURATION OF TREATMENT: ________________ WEEKS

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

1. WHAT IS THE REPORTED MORPHINE EQUIVALENCE DOSAGE IN THE RI PRESCRIPTION DRUG MONITORING PROGRAM? ________________________
2. RELEVANT CLINICAL DIAGNOSIS/ICD 10 CODES ASSOCIATED WITH PAIN: ____
3. IF ICD 10 IS CHRONIC PAIN WHAT IS UNDERLYING CAUSE OF PAIN : ____
4. WHAT IS THE INITIAL DATE OF PAIN DIAGNOSIS? _________ /________ /__________
5. **ATTACH A COPY OF THE MOST RECENT CLINICAL EVALUATION OF THE PAIN (NO MORE THAN 5 PAGES).**
6. **DESCRIBE EITHER AS A BRIEF SUMMARY OR ATTACH** A COPY OF MOST RECENT CLINICAL NOTES WHICH INCLUDES PAIN MANAGEMNT PLAN.

   ____

   ____
7. PAIN MANAGEMENT:
   a. IS THERE A REFERRAL TO PAIN MANAGEMENT? NO _______ YES _______, WHAT IS (WAS) THE DATE OF APPOINTMENT ______ /_____ /______
   b. IF PAIN MANAGEMENT CONSULTATION WAS IN THE PAST/COMPLETED**, ATTACH COPY OF CONSULTATION REPORT**.
8. MEDICATION HISTORY: LIST MEDICATIONS USED TO TREAT PAIN ASSOCIATED WITH DIAGNOSIS.

	PREFERRED DRUG TRIED	DAILY DOSE	START DATE	END DATE	WHY DISCONTINUED?
1			/ /	/ /	
2			/ /	/ /	
3			/ /	/ /	

PRESCRIBER ATTESTATION AND 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 __________________