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

PA000 - General

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 RELEVANT MEDICATIONS USED TO TREAT DIAGNOSIS.

	RELEVANT MEDICATION HISTORY	DAILY DOSE	START DATE	END DATE	OUTCOME OR WHY DISCONTINUED?
1			/ /	/ /	
2			/ /	/ /	
3			/ /	/ /	

4. **DESCRIBE WHY THIS SPECIFIC MEDICATION 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 _________________

Revised 03.2022