Medical Benefit (HCPCS/J-Code) Drug Prior Authorization Form

Phone: (855) 322-4075
Fax: (866) 508-6445

Date of Request:	**Pt's DOB:
**Pt. Name (Last):	**(First):
**Pt. ID (Medicaid or MiChild ID):	Name of Person Completing form:

(**Information is required for review of request. Please print clearly.*)

Requesting Provider Information:

Provider's Name		Provider's Specialty:		NPI Number (individual)
Provider Address	Provider City		Provider State	Provider Zip Code
Provider Phone #: (Area Code)	(Number)	Provider Fax #: (Area Code)	(Number)	

Facility Providing Service (Referring To):

Name of Treatment Facility		Facility NPI Number		Facility Tax ID
Facility Address	Facility City		Facility State	Facility Zip Code
Facility Phone #: (Area Code)	(Number)	Facility Fax #: (Area Code)	(Number)	

Requests for certain medications will require additional information be provided. To expedite the authorization process, please include the following information when requesting these types of medication:

□ **Hospital Discharge** □ **New Request** □ **Reauthorization**

Lab	LDL	A1c	BMI	BP	BUN	Creatinine
Value						
Draw Date						

HCPCS (J-Code) Requested: ***One HCPCS (J-Code) request per form***

HCPCS (J-Code	ICD	Name	Strength	Dose	Quantity/Total Units

Estimated length of need:

Diagnosis:

Previous medications prescribed and outcome:

List all service/supply HCPCS codes that corresponds with the requested J code

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: ______________________________ **Date:** ______________________________

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