



**GENERAL PHARMACY/DRUG PA FORM**  
**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)**  
**Hewlett Packard Enterprise 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 (        ) \_\_\_\_\_

\_\_\_\_ ARE YOU AN OUT OF STATE PHARMACY PROVIDER? (N/Y) IF YES, NPI # \_\_\_\_\_

PHARMACY NAME \_\_\_\_\_

DRUG REQUESTED \_\_\_\_\_ QTY/FILL \_\_\_\_\_

**INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD 10 CODE.**

\_\_\_\_ INDICATE RELEVANT DIAGNOSIS?

\_\_\_\_\_ ICD10 CODE \_\_\_\_\_

EXPLAIN WHY THIS PARTICULAR MEDICATION IS MEDICALLY NECESSARY FOR THIS PATIENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 HEWLETT PACKARD ENTERPRISE CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100**

FOR STATE USE ONLY:

APPROVAL: \_\_\_\_ YES \_\_\_\_ NO    PRIOR AUTHORIZATION #: \_\_\_\_\_

EFFECTIVE DATES: FROM: \_\_\_\_\_ TO \_\_\_\_\_