



**PA17 - QALAAQUIN**  
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)  
DXC Technology · 301 Metro Center Blvd., 3rd Floor · Warwick, RI 02886  
FAX 401-784-3889 ATTN: PHARMACIST

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 MALARIA? 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 DXC TECHNOLOGY CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100**

FOR STATE USE ONLY:

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

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