



Executive Office of Health & Human Services

MEDICAID FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM

DXC Technology 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:

RELEVANT CLINICAL DIAGNOSIS – LIST ICD-10 CODES: \_\_\_\_\_

1. DESCRIBE TREATMENT PLAN: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. 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.

c. HAVE YOU REVIEWED THE RI PRESCRIPTION DRUG MONITORING PROGRAM? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHAT IS YOUR PATIENT’S REPORTED MORPHINE EQUIVALENCE DOSAGE (MED)? \_\_\_\_\_

MEDICATION HISTORY: LIST THE MEDICATIONS USED IN THE PAST THAT ARE FROM THE SAME THERAPEUTIC DRUG CATEGORY

	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 \_\_\_\_\_