

Alabama Medicaid Pharmacy Miscellaneous PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Prescribing practitioner signature

Date

DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____ Drug Requested _____

DRUG/CLINICAL INFORMATION

Required for all requests

☐ Drug request – Complete this section

Quantity per month _____

☐ Compounding Professional Fee – Complete items marked ♦ and next section

PA Refills: 0 1 2 3 4 5 Other _____

♦ Diagnosis _____ ICD-9 Code* _____

♦ Diagnosis _____ ICD-9 Code* _____

♦ ☐ Initial Request ♦ ☐ Renewal

♦ Medical justification _____

♦ ☐ Additional medical justification attached.

☐ EPSDT Referral form attached

*See Instruction Sheet, Section 4

COMPOUNDING SPECIFIC INFORMATION

Compounding Ingredients (Ing.)

Ing. Name _____ Ing. Name _____

Ing. Name _____ Ing. Name _____

If more ingredients are required, attach additional sheets.

Compounding Time

Units Requested (in minutes)

FOR HID USE ONLY

☐ Approve request

☐ Deny request

☐ Modify request

☐ Medicaid eligibility verified

Comments _____

Reviewer's Signature

Response Date/Hour