ALASKA DIVISION OF HEALTH CARE SERVICES
REQUEST FOR PRIOR AUTHORIZATION

PRESCRIBING PHYSICIAN:	
FIRST NAME	LAST NAME
PHONE NUMBER	MEDICAID ID NUMBER
FAX NUMBER	

MEDICAID PATIENT:	
FIRST NAME	LAST NAME
DIVISION OF MEDICAL ASSISTANCE ID NUMBER	
DATE OF BIRTH	SEX

DISPENSING PHARMACY:		
NAME	PHONE NUMBER	FAX NUMBER

AUTHORIZATION DATES:	
REQUEST DATE	BEGIN DATE

PLEASE DOCUMENT BELOW THE APPROPRIATE CLINICAL INFORMATION FOR AUTHORIZING THIS MEDICATION AND RETURN TO THE FAX NUMBER LISTED BELOW. THANK YOU FOR YOUR COOPERATION.

NOTE: INCOMPLETE REQUESTS WILL BE DENIED UNTIL ALL REQUIRED INFORMATION IS RECEIVED.

REQUESTED MEDICATION

CHECK BOX TO LEFT OF REQUESTED MEDICATION AND SUPPLY STRENGTH AND DAILY DOSE

This form may also be used for requesting to exceed the maximum allowed units.

		STRENGTH	DAILY DOSE
		STRENGTH	DAILY DOSE
		STRENGTH	DAILY DOSE

DIAGNOSIS FOR REQUESTED MEDICATION

OTHER PERTINENT MEDICATION PREVIOUSLY TAKEN

MEDICATION NAME	STRENGTH	DAILY DOSE	DATE STARTED	DATE STOPPED
MEDICATION NAME	STRENGTH	DAILY DOSE	DATE STARTED	DATE STOPPED
MEDICATION NAME	STRENGTH	DAILY DOSE	DATE STARTED	DATE STOPPED

PRESCRIBER'S SIGNATURE SPECIALTY

FIRST HEALTH SERVICES USE ONLY:	**[ ] APPROVED [ ] CHANGED [ ] DENIED**
DATE	LENGTH OF AUTHORIZATION
MAP PHARMACIST / TECHNICIAN	COMMENTS
NDC NUMBER	

SUBMIT REQUESTS TO: FIRST HEALTH SERVICES FAX: (888) 603-7696 TELEPHONE: (800) 331-4475

REVISED 5/23/06