District of Columbia Pharmacy Program

DC Pharmacy Services PA

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

PATIENT'S DATE OF BIRTH / /

PATIENT'S FULL NAME

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER: – –

PRESCRIBER FAX NUMBER: – –

PRESCRIBER DEA #: –

PRESCRIBER NPI #: –

PERSON COMPLETING FORM:

PHARMACY NAME:

PHARMACY PHONE NUMBER:

Drug Requested *(Use one form per drug)*:

Strength

Quantity

Directions

Type PA

☐ Non-PDL PA ☐ Narcotic PA ☐ Brand Necessary ☐ Injectable PA ☐ Exceed Qty Limit ☐ Other

Requested Start Date of Medication: / /

Expected Duration of Therapy:

1. **Diagnosis for use of this medication?**
2. **Can a preferred medication be used by this patient?** ☐ Yes ☐ No
   (If no, skip #3 and state reason below)
3. **Can the current drug or agent be used within DC Medicaid criteria?** ☐ Yes ☐ No
   (If no, skip #3 and state reason below)

Reason for use of requested drug or agent needed for prior approval

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

FAX TO: District of Columbia Pharmacy Program
Phone: 1-800-273-4962
Fax: 1-866-535-7622

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