

ALASKA DIVISION OF HEALTH CARE SERVICES REQUEST FOR PRIOR AUTHORIZATION

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

MEDICAID/CAMA PATIENT:	
FIRST NAME	LAST NAME
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

PRESCRIBER'S SIGNATURE _____ SPECIALTY _____

FIRST HEALTH SERVICES USE ONLY:	<input type="checkbox"/> APPROVED <input type="checkbox"/> CHANGED <input type="checkbox"/> 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