

OHIO DEPARTMENT OF MEDICAID

Request for Rx Prior Authorization

Not to be used for: Synagis, Buprenorphine Products or Hepatitis C Medication PA Requests

Request Date: ____/____/____

Patient Medicaid ID#: _____ _____	Prescriber's Full Name: _____ _____
Patient DOB: ____/____/____	Provider NPI #: _____
Patient's Full Name: _____ _____	Prescriber Address: _____ _____
Age: _____ Height: _____ Wt: _____ Sex: _____	Prescriber Ph#: _____ Prescriber Fax#: _____

If Known:

Pharmacy Name: _____ Pharmacy Ph#: _____

Drug Requested: _____	Strength: _____	Route: _____	<input type="checkbox"/> New
Frequency: _____	Duration of Therapy: _____	Quantity: _____	<input type="checkbox"/> Renewal

Diagnosis and/or ICD-10 code (MUST BE INCLUDED TO AVOID DELAYS): _____

Pertinent past or present therapies (including OTCs and non-pharmacological):

Drug and Dose / Route / Frequency / Start Date / Stop Date / Outcome

Additional significant information for requesting a non-preferred drug(i.e. allergy, contraindications, drug-drug interactions, lab results etc.): _____

Physician's Signature: _____ Date: ____/____/____
(or agent of prescriber)

Fax To: OHIO Department of Medicaid
Fax: **(800) 396 - 4111** PA Helpdesk: **(877) 518 - 1546**
Hours: Monday – Friday 8:00 am – 8:00 pm EST