

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 Number		Prescriber's Full Name	
Patient Date of Birth		Provider NPI Number	
Patient's Full Name		Prescribers Address	
Age	Height	Prescribers Phone Number	
Weight	Sex	Prescribers Fax Number	
(If Known) Pharmacy Name		Pharmacy Phone Number	
Drug Requested	Strength	Route	
Frequency	Duration of Therapy	Quantity	New 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>(i.e. allergy, contraindications, drug-drug interactions, lab results etc.)</i>

☐ I attest that I am a member of the prescriber's staff in accordance with OAC 5160-9-03:
Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

Physician's Signature: _____ Date: _____
(or staff of prescriber; IF a staff member is attesting, please PRINT your name _____)

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