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.e. allergy, contraindications, drug-drug interactions, lab results etc.)*

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

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Physician's Signature *(or agent of prescriber)* Date