



FLORIDA MEDICAID PRIOR AUTHORIZATION

Pharmacy – Miscellaneous

Maximum length of approval = 12 months or less

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Drug: _____ Quantity: _____ Dosage and Frequency of Dosing: _____

Diagnosis: _____

Previous Therapy (include drug, dose, and duration):

- 1. Date of trial: _____
2. Date of trial: _____

Reason for Discontinuing Previous Therapy:

Allergic reaction, contraindication, and/or drug interaction (please specify all and submit progress notes to support):

Line for Allergic reaction details

Therapeutic Failure (please provide lab data, discharge summaries, or progress notes):

Line for Therapeutic Failure details

Continuation of Therapy:

Patient has a documented positive response to therapy (progress notes required):

Line for Continuation of Therapy details

Medical records supporting requested therapy over other preferred medications listed on the Florida Medicaid Preferred Drug List are required. This list may be found at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/.

Large empty box for medical records

Prescriber's Signature _____ Date: _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-800-310-6826

02.01.2025

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