Reset Form Print Form

United Healthcare Community Plan

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#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

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**):

_____

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

_____

Continuation of Therapy:

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

_____

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/.

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