MICHIGAN DEPARTMENT OF COMMUNITY HEALTH PHARMACY PROGRAM:
PRIOR AUTHORIZATION (PA) REQUEST

Fax requests to: 1-888-603-7696 or call into: 1-877-864-9014

PRESCRIBING PHYSICIAN IS RESPONSIBLE FOR THE ACCURACY OF INFORMATION PROVIDED

PRESCRIBING PHYSICIAN:

Name: _____
First Last

Physician specialty: _____

Requested start date of PA: _____

Person completing form: _____
Name Title Date

Direct phone & ext #_____

BENEFICIARY:

Name: _____
First Last

Beneficiary ID number: _____

Date of birth _____

Fax #: (_____)_____

PHARMACY: _____ Phone #: (_____)_____

DRUG NAME	STRENGTHS	DOSE	DURATION OF RX

1. **Diagnosis** for use of this medication: _____

2. **Can a preferred medication be used** by this patient? ❒ NO: reason below:

_____

3. **Reason for the exception request**: Previous history of a medical condition, allergies, lab or test results, and/or other pertinent medical information.

_____

_____

4. **Names of previous medications** tried for this condition. Please list the reasons for therapeutic failure.

_____

_____

First Health Services Use Only

Reviewed Date: _____ ❒ Approved ❒ Denied ❒ Prescriber Changed

Authorized time frame: ___/___/___ TO ___/___/___ ❒ **Returned for information** on _____

MAP RPh/Tech: _____ Comments: _____

_____

PHYSICIAN RESPONSE: _____ DATE_____

_____

Mail requests to: First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060

Effective: August 1, 2002