Prior Authorization/Non-Formulary Medication Request

MedStar Family Choice
DISTRICT OF COLUMBIA

Please fax to: 202-243-6258

All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-DC MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL.

MedStar Family Choice District of Columbia – Fax Number: 202-243-6258 Phone Inquiries: 855-798-4244

Patient Name:	**Patient DOB:**
Patient Phone #:	**Medicaid ID#:**

Reason for Medication Request:

☐ Prior Authorization	☐ Non-Formulary Medication Request
☐ Increase in Dosage/Frequency	☐ Vacation Supply
☐ Lost/Stolen Medication	☐ Out of Medication

Medication Requested (*Dose and Frequency*) or **Diabetic Device Requested** (*List all components*):

****Is the Enrollee currently using this medication/device: ☐ Yes ☐ No**

Please check that the following has been included with medication request:

☑	**Requirement(s)**
☐	Last Clinical/Office visit note
☐	Pertinent Laboratory Findings (if applicable)
☐	History of Previous Medications Used to Treat Condition
☐	Prior Authorization Table has been checked for medication criteria and submission requirements on: MedStarFamilyChoiceDC.com/providers/pharmacy
☐	MedStar Family Choice District of Columbia Drug Formulary has been reviewed for alternatives

Diagnosis Code(s) /ICD-10:

Pharmacy Name: **Phone:**

*****Please provide all clinical notes to support the request and fax to the number above*****

By signing below, I certify that the information provided is accurate and that all the relevant medical records listed above are included in this submission.

Prescriber Signature: **Date:**

Provider Name/Office: **NPI#**

Provider Phone: **Provider Fax:**

Contact Person Name:

Contact Phone w/ext: **Contact Fax:**