Prior Authorization Pharmacy Request

MedStar Family Choice

DISTRICT OF COLUMBIA

Date: _____

MFC - District of Columbia Fax: (202) 243-6258

☐ **Vacation** ☐ **Lost Medication** ☐ **MD Increased Dose/Frequency** ☐ **Medication Stolen**

☐ **Out of Medication**

Enrollee Name: (*Please print*) _____DOB: _____

Enrollee MedStar Family Choice ID #: _____ **Medicaid ID #:** _____
(*ID begins with **61**…)*

Provider Name/Office: _____ **NPI#**_____

Provider Phone: _____ **Provider Fax:** _____

Contact Person Name: _____

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

(If different from above)

Medication Requested (*Dose and Frequency*):_____

****Is the member currently on this medication:** ☐ **Yes** ☐ **No**

Include Previous Medications: _____

Please consult the MedStar Family Choice formulary before submitting for prior authorization

Diagnosis Code(s) /ICD-10:_____

Pharmacy Name: _____ **Phone:** _____

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

☐ **Approved** ☐ **Denied** **MFC Reviewer:** _____