# Alabama Medicaid Pharmacy
# Miscellaneous PA Request Form

**FAX: (800) 748-0116**
**Phone: (800) 748-0130**

**Fax or Mail to**
**Health Information Designs**

**P.O. Box 3210**
**Auburn, AL 36823-3210**

## PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ❒ Yes

## PRESCRIBER INFORMATION

Prescriber name _____ NPI #_____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

**I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.**

_____
Prescribing practitioner signature Date

## DISPENSING PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____ Drug Requested _____

## DRUG/CLINICAL INFORMATION
**Required for all requests**

❒ EPSDT/Medical Necessity Request Quantity per month _____ Days supply _____

❒ Compounding Max Cost Override Request PA Refills: 0 1 2 3 4 5 Other_____

Drug Requested _____

Diagnosis _____ ICD-9/ICD-10 Code _____

Diagnosis_____ ICD-9/ICD-10 Code _____

❒ Initial Request ❒ Renewal

Medical justification _____

❒ Additional medical justification attached ❒ EPSDT Referral Form attached

For compounding max cost override requests, please include the following:

Compounding Ingredients:

Ingredient Name_____ Quantity Required _____ NDC _____

Ingredient Name_____ Quantity Required _____ NDC _____

Ingredient Name_____ Quantity Required _____ NDC _____

Ingredient Name_____ Quantity Required _____ NDC _____

If more ingredients are required, attach additional sheets.

## FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____
Reviewer's Signature Response Date/Hour