Alabama Medicaid Pharmacy
Miscellaneous PA Request Form

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

Fax or Mail to
KEPRO

P.O. Box 3570
Auburn, AL 36831-3210

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-10 Code_____

Diagnosis_____ 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 KEPRO USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments_____

_____
Reviewer's Signature Response Date/Hour