PRIOR AUTHORIZATION REQUEST FORM FOR
MATERNAL CARE PLAN AND TRAUMA PROGRAM ONLY

FAX COMPLETED FORMS TO: (405) 213-1521

Important: Use one request form per drug
Incomplete forms will not be processed

Member ID#

Member Date of Birth (MM/DD/YYYY)

Member Name (Last, First)

Prescriber Name (Last, First)

Prescriber NPI#

Prescriber Phone#

Prescriber Fax#

Drug Name

Strength

Directions

Quantity

Refills

Diagnosis (Do not use ICD codes)

Please describe/explain why patient cannot utilize a formulary medication. Please include a list of medications that the patient has previously tried, including doses, durations, and reasons for discontinuation:

Retail Pharmacy Member Utilizes

Retail Pharmacy Phone#

HCD Clinic Pharmacy Location Member Utilizes (Please circle one location)

West Palm Beach	Lantana	Delray Beach	Belle Glade	Jupiter
1150 45th Street	1250 Southwinds Dr.	225 S. Congress Ave	941 SE 1st	411 W Indiantown Rd
561-209-2577	561-209-2575	561-209-2570	561-209-2580	561-209-2572

Provider Signature

Date (MM/DD/YYYY)

For questions regarding completion or processing of this form, please contact MaxCareRX at 800-259-7765 (Opt 1).

The approval for this request is subject to member active eligibility status/criteria and specific plan coverage and limitations.

Confidentiality Statement

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