

# 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#**

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**Member Date of Birth (MM/DD/YYYY)**

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**Member Name (Last, First)**

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**Prescriber Name (Last, First)**

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**Prescriber NPI#**

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**Prescriber Phone#**

--	--	--	--	--	--	--	--	--	--	--	--

**Prescriber Fax#**

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**Drug Name**

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**Strength**

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**Directions**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Quantity**

--	--	--	--	--

**Refills**

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**Diagnosis (Do not use ICD codes)**

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**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**

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**Retail Pharmacy Phone#**

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**HCD Clinic Pharmacy Location Member Utilizes (Please circle one location—if applicable)**

West Palm Beach 1150 45 <sup>th</sup> Street 561-209-2577	Lantana 1250 Southwinds Dr. 561-209-2575	Delray Beach 225 S. Congress Ave 561-209-2570	Belle Glade 39200 Hooker Hwy 561-209-2580
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**Provider Signature**

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**Date (MM/DD/YYYY)**

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**For questions regarding completion or processing of this form, please contact Health Care District Pharmacy Prior Authorization Department at 561-804-5600 x291200 or x291212.**

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

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