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

Health Care District PALM BEACH COUNTY

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—if applicable)

West Palm Beach 1150 45th 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

Provider Signature

Date (MM/DD/YYYY)

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.