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—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.

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