Idaho Medicaid Prior Authorization Request Form for Prescriptions

I. Provider Information		II. Member Information
Prescriber name (print):		Member name:
Prescriber Specialty:		Identification number:
Fax:	Phone:	Date of Birth:
Office Contact Name:		Medication allergies:

III. Drug Information *(One drug request per form)*

Drug name and strength:	Dosage form:	Dosage interval (sig):	Qty per Day:

Diagnosis relevant to ***this*** request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?

☐ yes; How Long?_____ [go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?

☐ yes [go to item C] ☐ no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?

☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The **Peach State Health Plan Preferred Drug List (PDL)** is available on the **Peach State Health Plan** website at **www.pshpgeorgia.com.**

IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date: