



Drug Prior Authorization Request Form

(MAP-82101, revised 5/15/07)

FAX to 800-365-8835 (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

Not to be used for PPI/H2 Blocker, Brand Name, or Atypical Antipsychotic Agents PA requests.
Please use specific forms.

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

SUBMITTED BY : Prescriber Pharmacy

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
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First Health is directed to FAX a response to the following fax number (s):	Prescriber Fax # (Print Clearly)	and /or	Pharmacy Fax # (Print Clearly)

	PRESCRIBER Information	PHARMACY Information	
Name			
Phone # <i>(Not fax number)</i>			
State License # or NPI <i>(Not DEA #)</i>		NPI # <i>(Not DEA #)</i>	

	Drug Requested <i>(Use separate form to request more than 4 drugs.)</i>	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code <i>(if known)</i>
1							
2							
3							
4							

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? Yes No Unknown

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION *(including drugs already tried)* _____

