Medicaid Medical Drug Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

☐ Standard Review ☐ Urgent Review (life threatening)

Date Submitted: _____

Patient Information

Last Name: _____ First Name: _____

10-Digit Medicaid ID #: _____ DOB: _____ Gender: _____

Current Weight: _____ ☐ **kg** ☐ **lbs** Current Height: _____ ☐ **in** ☐ **cm**

Prescriber Information

Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Address: _____

Prescriber NPI: _____ Prescriber Specialty: _____

Office Contact Name: _____ Office Contact Phone: _____

Product Information

Drug name: _____ Requested dose: _____

HCPCS code: _____ Requested frequency: _____

Billing Information

Administration:

☐ Prescriber's Office

☐ Outpatient Infusion Center

Facility: _____ NPI: _____ Fax: _____

☐ Home Infusion

Agency: _____ NPI: _____ Fax: _____

Billing:

☐ Prescriber to buy and bill

☐ Facility to buy and bill

☐ Home Infusion agency to buy and bill

☐ Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Code:

Primary: _____

Secondary: _____

Tertiary: _____

Billing considerations:

- The billing provider must be actively enrolled in the State of Michigan CHAMPS program for every date-of-service billed.
- The provider must be in-network with Priority Health Medicaid on every date-of-service billed.
- Out-of-network providers must obtain special authorization. Use form located here:
  priorityhealth.com/provider/manual/forms/medical-device-auth-forms

All fields must be complete and legible for review. Prescriber's office will receive a response via fax. Last reviewed 03/2023

Priority Health

Clinical Documentation

A. This request is for:

☐ New therapy
☐ Continuation of therapy

When did the patient first start using this medication? _____

What was the date of the patient's last dose? _____

When is the patient's next dose due/scheduled? _____

B. What diagnosis is this drug being requested for? _____

C. What medications has the patient previously used for this condition?

Drug	Dose	Dates	Clinical Outcome

D. Supporting Statement:

Documentation (chart notes, labs, studies, etc.) supporting all information must be included with request

_____

_____

_____

_____

_____

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Prescriber's office will receive a response via fax. Last reviewed 03/2023