# VIRGINIA MEDICAID REQUEST FOR DRUG PRIOR AUTHORIZATION	**COMMONWEALTH of VIRGINIA** *Department of Medical Assistance Services*

Requests for prior authorization (PA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**
THIS FORM SHOULD NOT BE USED FOR PA REQUESTS FOR WEIGHT LOSS DRUGS

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

Requests may be mailed to: First Health Services Corporation / 4300 Cox Road / Glen Allen, VA 23060 / ATTN: MAP

PATIENT INFORMATION	
Patient's Name:	Patient's Diagnosis:
Patient's Medicaid ID#: (12 digits)	
Patient's Date of Birth:	

DRUG INFORMATION	
Drug Name, Dosage Form & Strength:	Quantity Per Day:
Has patient had previous pharmaceutical therapy for the above diagnosis?	☐ Yes ☐ No
Does the patient reside in a Long Term Care facility?	☐ Yes ☐ No

List pharmaceutical agents attempted and outcome:

1.

2.

3.

Medical necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit:

PHYSICIAN INFORMATION	
Physician's Name (print):	Today's Date:
Physician's Signature:	Authorization begin date:
Physician's DEA#:	Phone #: ( )
Physician's National Provider ID#:	Fax #: ( )

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS

FAX TO 800-932-6651

PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE

PDL and Weight Loss PA forms are available at
http://www.dmas.virginia.gov/pharm-home.htm or http://virginia.fhsc.com.