

FLORIDA MEDICAID  
Prior Authorization  
Pharmacy - Miscellaneous



Beneficiary's Medicaid ID#  
[Grid for 10 digit ID number]

Date of Birth (MM/DD/YYYY)  
[Grid for MM/DD/YYYY]

Beneficiary's Full Name  
[Grid for full name]

Prescriber's Full Name  
[Grid for prescriber name]

Prescriber License # (ME, OS, RN)  
[Grid for license number]

Prescriber Phone Number  
[Grid for phone number]

Prescriber Fax Number  
[Grid for fax number]

Pharmacy Name  
[Grid for pharmacy name]

Pharmacy Medicaid Provider #  
[Grid for provider number]

Pharmacy Phone Number  
[Grid for pharmacy phone number]

Pharmacy Fax Number  
[Grid for pharmacy fax number]

Drug: \_\_\_\_\_ Quantity: \_\_\_\_\_ Dosage and Frequency of Dosing: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Previous Therapy (include drug/dose/duration): \_\_\_\_\_

Medical Rationale for Non-PDL Request: \_\_\_\_\_

Pertinent Lab Data: \_\_\_\_\_ Other Pertinent Information: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**Please attach a copy of the original prescription.**  
**Please attach lab results and other medical documentation to support request. The provider must retain copies of all documentation for five years.**

Fax or mail completed forms to:  
First Health Services Corporation (FHSC)  
Prior Authorization  
P. O. Box 7082  
Tallahassee, FL 32314-7082  
Phone: (877) 553-7481  
Fax: (877) 614-1078

For AHCA Use Only			
DATE: _____		NOTIFIED: _____	
APPROVED: _____	START DATE: _____	EXPIRATION DATE: _____	
DENIED: _____	REASON: _____		