COLORADO PRIOR AUTHORIZATION FORM

Phone: 1-866-840-1877 **Fax:** 1-866-678-8301 **Request Date:** / /

PATIENT INFORMATION

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** –

PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

STREET ADDRESS:

CITY: **STATE:** **ZIP**

PHONE NUMBER: – – **FAX NUMBER:** – –

NPI NUMBER: **DEA NUMBER:** –

DRUG INFORMATION

DRUG REQUESTED:

STRENGTH: **QUANTITY:** **FREQUENCY OF DOSING:**

DIAGNOSIS: **METHOD OF DIAGNOSIS (IF APPLICABLE):**

FAILED MEDICATIONS:

CONTRAINDICATIONS/ALLERGIES:

CURRENT MEDICATIONS:

RELEVANT LAB VALUES: **DATE OF LAB RESULTS:**

MEDICAL JUSTIFICATION:

WHERE WILL MEDICATION BE ADMINISTERED? (CHECK ONE):

☐ Member's Home ☐ Long-Term Care Facility ☐ Dr.'s Office ☐ Dialysis Unit or Hospital

FOR MEDICATIONS ADMINISTERED IN MEMBER'S HOME BY HOME HEALTH AGENCY OR HEALTH CARE PROFESSIONAL (HOME HEALTH SERVICE)

Name of Agency or Health Care Professional:_____Phone number: _____

If applicable for Home Health Authorizations: Authorization number:_____Approved Dates: _____

FOR MEMBERS RECEIVING MEDICATION IN A LONG-TERM CARE FACILITY

Name of Facility:_____Phone number: _____

Prescriber Signature (Required) ***Date***

(By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records)

Fax This Form to:
WITHME HEALTH
FAX NUMBER: 1-866-678-8301
PA HELP DESK: 1-866-840-1877

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is against the law. **If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.**