

Prior Authorization Medication Request



MedStar Family Choice

Date: _____

MFC - Maryland Fax: (410) 933-2274

- Vacation
- Lost Medication
- MD Increased Dose/Frequency
- Medication Stolen
- Out of Medication

Member Name: *(Please print)* _____ DOB: _____

Member MedStar Family Choice ID #: _____ Medicaid ID #: _____
(MFC ID begins with 91...)

Provider Name/Office: _____ NPI# _____

Provider Phone: _____ Provider Fax: _____

Contact Person Name: _____

Contact Phone w/ext: _____ Contact Fax: _____
(If different from above)

Medication Requested *(Dose and Frequency)*: _____

****Is the member currently on this medication:** Yes No

Include Previous Medications: _____

*****Please consult the MedStar Family Choice formulary before submitting for prior authorization*****

Diagnosis Code(s) /ICD-10: _____

Pharmacy Name: _____ Phone: _____

*****Please provide all clinical notes to support the request and fax to the number above*****

Approved Denied MFC Reviewer: _____