Prior Authorization Non-Formulary Medication Request

Date: ________________________

MFC - Maryland Fax: (410) 933-2274

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: ____

Medical Reason for non-formulary request: ____

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__**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:** ________________________________