FAX completed form to
Change Healthcare
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program

PHONE:
For questions or inquiries (ONLY)
1-877-207-1126

Physician-Administered Medication Prior Authorization Request Form

Provider must fill in ALL information below. It must be legible, correct and complete or form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: ____ DOB: ____________________

Pay-to Provider's NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pay-to Provider's Taxonomy:____

Pay-to Provider's Full Name: ____ Phone: ___________________

Pay-to Provider's Address: ____ Fax: _____________________

Servicing Provider NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Servicing Provider's Full Name: ____ Phone: ___________________

Servicing Provider's Address: ____ Fax: _____________________

Drug Name (Only 1 Drug per Form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

1. Is this only a dose or quantity change from a previously approved PA? ☐ **Yes** ☐ **No**
2. Can the previously approved PA be cancelled? ☐ **Yes** ☐ **No**

Medical Necessity Documentation Required: (Attach copies of supporting documentation.)

3. Client's Medical Diagnosis____

4. Why is this medication necessary for this client? Include HCPC Code(s) as applicable____________________

____

5. Other clinical documentation or justification as applicable ____

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Prescriber Signature: ______________________ Date of Submission: ________________

**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***