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 <u>only</u> a dose or quantity change from a previously approved PA? ☐ **Yes** ☐ **No**
2. Can the previously approved PA be cancelled? ☐ **Yes** ☐ **No**

<u>Medical Necessity Documentation Required</u>: **(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 _____

_____

_____

_____

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.***