Alaska Medicaid

General Prior Authorization Form

Fax this form to (888) 603-7696

Form available on Alaska Medicaid's Medication Prior Authorization website.

This form may also be used for requests to exceed the maximum allowed units.

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: ________________

REQUESTOR INFORMATION

Requestor Name: ________________________________ Title: ________________________

MEMBER INFORMATION

Last Name: ____________________________ First Name: ____________________________

Member ID #: ___________________________ Date of Birth: ___________________________

Sex: ☐ Male ☐ Female Member Phone: _________________________

PRESCRIBER INFORMATION

Last Name: ____________________________ First Name: ____________________________

Prescriber NPI: _________________________ Specialty: ______________________________

Prescriber Phone: _______________________ Prescriber Fax: __________________________

PHARMACY INFORMATION

Pharmacy Name: ___________________________ Pharmacy NPI: ____________________

Pharmacy Phone: _______________________ Pharmacy Fax: __________________________

DRUG INFORMATION

Drug Name: ____ NDC: ____________________

Drug Strength: __________________________ Dosage Form: ___________________________

Dosage Schedule: _______________________ Quantity: _________ Day Supply: __________

Is this a physician-administered drug? ☐ Yes ☐ No

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Last Name: ______________________________ First Name: ______________________________

CLINICAL INFORMATION

1. Primary Diagnosis:

2. Other Diagnoses:

3. Current Medications:

4. Medical Justification (including previous failed therapies with dates):

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: ____________________________________ **Date:** _________________

(required)

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: (800) 331-4475

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