Idaho ADAP Program
Prior Authorization Drug Approval Form
General PA Form

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. **Patient's Diagnosis:** _____
2. **If this is a request for Subutex (Buprenorphine only), is the client pregnant?** ☐ Yes ☐ No
3. **If plan quantity limits are exceeded, please document medical justification to exceed limits** _____
4.. **Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800424-5734
Fax: **1-800-424-7579**

Revision Date: 01/15/2018

Magellan Rx MANAGEMENT℠