



# Illinois Medicaid Pharmacy Prior Authorization Request Form

Fax completed form to patient's health plan:

Plan/MCO	PBM	Phone	Fax

Before submitting a Prior Authorization (PA) request, check for preferred alternatives on the current PDL found at: <https://www2.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx>

A) Reason for Request:  Initial Authorization Request  Renewal Request

B) Medication Billed Through (please ensure PA request is faxed to the correct department)

Pharmacy Benefit  Medical Benefit (Physician Administered)  Unknown

C) Patient Demographics:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
mm/dd/yyyy

9-Digit Health Plan Member ID # (required): \_\_\_\_\_ MCO (if applicable): \_\_\_\_\_

Is patient hospitalized:  YES  NO

Discharge Date: \_\_\_\_\_  
mm/dd/yyyy

PROVIDER STAMP HERE IF DESIRED

D) Prescribing Provider Information:

All prescribers must be enrolled in the Medicaid Prescribers IMPACT system:

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Contact Email (optional): \_\_\_\_\_ Contact Fax: \_\_\_\_\_

E) Pharmacy Information - Required if the Pharmacy is the requesting provider:

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Fax: \_\_\_\_\_ Pharmacy NPI (optional): \_\_\_\_\_

F) Representation:

I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
mm/dd/yyyy

Prior authorization alone is not a guarantee of benefits or payment. Actual availability of benefits is always subject to other requirements of the health plan, such as limitations and exclusions, and eligibility at the time services are provided. The applicable terms of a patient's plan control the benefits that are available. At the time the claims are submitted, they will be reviewed in accordance with the terms of the plan.

Patient Name: \_\_\_\_\_ 9-Digit Health Plan Member ID#: \_\_\_\_\_

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**G) Requested Prescription Information** (for additional requests, attach a separate copy of this page)

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosage Form: \_\_\_\_\_ Quantity: \_\_\_\_\_ Day Supply: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_ Duration of Therapy: \_\_\_\_\_

NDC (if available): \_\_\_\_\_ HCPCS Code (if medical billing): \_\_\_\_\_

Start Date of this Request: \_\_\_\_\_  
mm/dd/yyyy

Diagnosis (specific): \_\_\_\_\_

Diagnosis ICD-10 (if available): \_\_\_\_\_

Has the patient already started the medication?  YES  NO Date Started: \_\_\_\_\_  
mm/dd/yyyy

Place of infusion/injection (if applicable): \_\_\_\_\_

Facility Provider/TIN (if applicable): \_\_\_\_\_

**H) Rationale for Prior Authorization:** (e.g., history of present illness, past medical history, current medications, etc.); please attach chart notes to support the request.  
**Medicaid providers are encouraged to use equally efficacious and cost-saving preferred agents whenever possible. Previous medications used must be reflected in paid pharmacy claims.**

**I) Failed/Contraindicated Therapies:** (Include drug name, strength, dosing schedule, duration, and reason for discontinuation or contraindication).

**J) Will any current medications for this indication be discontinued if this drug is approved?**  
If so, list below:

**K) Specific goals of therapy/clinical benefit and other pertinent information:**  
(e.g., relevant diagnostic labs, measures, response to treatment, etc.)

**L) Supplemental Information:** Certain medications will require supplemental information to complete the request review. Please refer to the plan's website for additional information that may be necessary for review. Note that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Plans may require additional information based on the type of drug being requested that may require follow-up inquiries with the prescriber.

Patient Name: \_\_\_\_\_

9-Digit Health Plan Member ID#: \_\_\_\_\_