Arizona Health Care Cost Containment System (AHCCCS)
Arizona Department of Child Safety, Comprehensive Medical and Dental Program (CMDP)
Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)

Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Prescriber:
Pharmacy:
Patient:

OptumRx Prior Authorization Department

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This Medication Request Form is only for use by prescribing clinicians for AHCCCS FFS, CMDP and DDD members and must be signed by the prescribing clinician. In addition to member identifying data, the prescribing clinician must provide the medication requested, the dosage and the clinical justification/rationale for the request. If the request is for a drug not listed on the AHCCCS Drug List, the documentation must demonstrate why the member cannot use the medication(s) listed on the drug list. The Medication Request Form is also used to request overrides for step therapy, quantity limits and other edits. If you have any questions regarding this process, please contact OptumRx's Customer Service at (855) 577-6310. **Please complete this form and fax to OptumRx at (866) 463-4838.**

Retail & Long Term Care Pharmacy Instructions for After Hours Emergencies, Hospital Discharges & Care Transitions
The participating network pharmacy staffs are to contact the OptumRx's Customer Service Unit at (855) 577-6310 to request medication overrides for after-hours emergencies, hospital discharges or patients transitioning from the hospital to a lower level of care; this also includes antibiotics infusion requests.

☐ **CHECK HERE IF THE PATIENT IS A DIRECT TRANSFER FROM A HOSPITAL TO A LONG TERM CARE FACILITY.**

☐ **CHECK HERE TO REQUEST AN EXPEDITED (URGENT) REVIEW**: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Medication Request Information (please complete each section of this form prior to submission): *Denotes Required Fields

PATIENT INFORMATION		**PRESCRIBING CLINICIAN INFORMATION**	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID# / DEA#:	
*Health Plan:		*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-10 Code, if known):			
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
*Requested Drug:		Name:	
*Dose:	*Strength:	Phone: ( ) -	Fax: ( ) -
*Quantity: (per month)	Dosage Form: (Oral, Injection, etc.)	*Length of Treatment: (Please be specific.)	
*Clinical Justification for the Requested Medication:			
*Other Medications Tried and/or Failed (Please be specific, give detail.):			
Additional Information / Other Pertinent History:			
*Prescriber Signature Required:		*Date:	

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