

## Request for Prior Authorization- Specialty Medications

(Medicaid services only)

In order to efficiently process your authorization request, the information below must be completed.

<b>Member Information:</b> Full Name: _____ Address: _____ Telephone #: (____) _____ DOB: ____/____/____ Medicaid #: _____ Primary Insurance Name (COB): _____ Primary Insurance ID # and Effective Date: _____	
Requested Diagnosis Code: _____ Requested J, S or Q/ HCPCS Code: _____ Requested Number of Units: _____ DOS From: ____/____/____ to ____/____/____	
<b>Please use the Synagis specific prior authorization form for these specific requests</b>	
<b>Please send clinical notes and all supporting documentation</b>	
<b>Requesting Provider:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Telephone #: _____ Address: _____ Fax #: _____ Contact Name/Phone #: _____	<b>Servicing Provider/Facility:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Telephone #: _____ Address: _____ Fax #: _____ Contact Name/Phone #: _____

Submitted By: \_\_\_\_\_  
 (Please Print)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please submit all supporting documentation and any applicable information with this request form**

Utilization Management phone number: (800) 424-5891

Specialty Medication fax number: (888) 656-6101

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