

Prescription Drug Authorization Fax Project

Fax Number 360 725-2141

September 26, 2003

- MAA Staff will give fax requests the highest priority (not at expense of telephone calls)
- We will respond to all fax requests within 24 hours. Our hours of business – Monday through Friday, 9:00 a.m. through 4:45 p.m. (not including holidays) We will attempt to complete all fax requests that are received before 5:00 p.m. on the day preceding a weekend or holiday.
- If you do not receive a response to your faxed request within 24 hours of submitting a request, including weekends and State holidays, you may dispense an emergency fill of prescription drugs covered by the Medical Assistance Drug Program that require authorization. Please contact the Medical Assistance Pharmacy Program with justification within 72 hours of the fill date.
- Older claims – those filled over three business days prior to fax request being sent - will have a maximum response time of ten business days
- Notice will be sent to the pharmacy if it is determined we need to pend for physician information
- Pended cases will have a maximum response time from the prescriber of ten business from date receipt sent
- Prior Authorization request form must be sent in to MAA via fax
- **NOT ACCEPTING EMAIL REQUESTS AT THIS TIME**

Please note that you must call if requesting an authorization for a refill too soon or excessive fills.

We will continue to take calls for those patients that are waiting in the pharmacy, or to answer questions.



Prescription Drug Authorization Fax Request Form

Drug Utilization Review Team

Fax: (360) 725-2141

<http://maa.dshs.wa.gov/pharmacy/>

Phone: 1-800-848-2842 Monday – Friday 9:00am to 4:45pm

Assuring the highest quality of care by guiding the appropriate use of drugs for Medicaid clients.

*******Please note: You must transmit a claim prior to faxing this form.*******

Authorization Type

- Update to existing authorization # _____
- New request**If requesting authorization for a refill too soon or excessive fills, you **MUST** call.

Pricing Conflicts

- Reimbursement less than cost
- DAW**If DAW, has patient tried generic? _____ Outcome? _____

Patient Information

Name _____

PIC

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Nursing Home Patient? Y N Unk

History of GI bleed? Y N Unk

Diagnosis/medical justification _____

What alternatives have been tried? Dates? _____

Pharmacy Information

Pharmacy Name _____

NABP _____

Fax: _____

Prescriber Information

Prescriber Name _____

DEA# _____

Specialty _____

Phone _____

Fax _____

Drug Information

Drug name _____

Rx# _____

NDC _____

Directions for use (sig) _____

Quantity _____

Date(s) of fill _____

Days supply _____

FOR DSHS/MAA STAFF USE ONLY

Form not complete or illegible. Unable to process request. Please complete and refax

Meets EPA# _____

Authorized. Use # _____

Request received. Pending for more information/justification from physician.

Denied

Other _____

Name of contact person @ Rx _____

If you have not received a response within 24 business hours, please contact us.

MAS _____

Date _____