COLORADO
Department of Health Care Policy & Financing

PRIOR AUTHORIZATION FORM

Phone: 1-800-424-5725 **Fax:** 1-800-424-5881 **Request Date:** / /

PATIENT INFORMATION

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** –

PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

STREET ADDRESS:

CITY: **STATE:** **ZIP:**

PHONE NUMBER: – –

FAX NUMBER: – –

NPI NUMBER: **DEA NUMBER:** –

DRUG INFORMATION

DRUG REQUESTED:

STRENGTH: **QUANTITY:** **FREQUENCY OF DOSING:**

DIAGNOSIS: **METHOD OF DIAGNOSIS (IF APPLICABLE):**

FAILED MEDICATIONS:

CONTRAINDICATIONS/ALLERGIES:

CURRENT MEDICATIONS:

RELEVANT LAB VALUES: **DATE OF LAB RESULTS:**

MEDICAL JUSTIFICATION:

WHERE WILL MEDICATION BE ADMINISTERED? (CHECK ONE):

☐ Member's Home ☐ Long-Term Care Facility ☐ Dr.'s Office ☐ Dialysis Unit or Hospital

FOR MEDICATIONS ADMINISTERED IN MEMBER'S HOME BY HOME HEALTH AGENCY OR HEALTH CARE PROFESSIONAL (HOME HEALTH SERVICE)

Name of Agency or Health Care Professional: _____ Phone number: _____

If applicable for Home Health Authorizations: Authorization number: _____ Approved Dates: _____

FOR MEMBERS RECEIVING MEDICATION IN A LONG-TERM CARE FACILITY

Name of Facility: _____ Phone number: _____

Requests that do not include the required information will experience a delay in the approval process. To expedite this process, please review the prior authorization criteria in Appendix P at https://www.colorado.gov/hcpf/provider-forms#PDLP or in the Preferred Drug List at https://www.colorado.gov/hcpf/provider-forms#PDL.

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records)

Fax This Form to:
COLORADO MEDICAID PRIOR AUTHORIZATIONS
FAX NUMBER: 1-800-424-5881
PA HELP DESK: 1-800-424-5725

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