COLORADO
Department of Health Care Policy & Financing

PRIOR AUTHORIZATION FORM

For specialty medications administered in the hospital setting

Email to: HCPF_PharmacyPAD@state.co.us

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:**

PRESCRIBER SPECIALTY:

DRUG INFORMATION

DRUG REQUESTED:

STRENGTH: _____ **QUANTITY:** _____ **DIRECTIONS FOR USE:** _____ **DURATION OF THERAPY:** _____

ICD-10 CODE: _____ **DIAGNOSIS (DESCRIPTION):** _____ **METHOD OF DIAGNOSIS (IF APPLICABLE):** _____

FAILED MEDICATIONS OR TREATMENTS: _____

CONTRAINDICATIONS/ALLERGIES: _____

CURRENT MEDICATIONS: _____

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

MEDICAL JUSTIFICATION: _____

ANTICIPATED CLINICAL OUTCOME/TREATMENT GOAL: _____

OTHER SUPPORTIVE CARE MEMBER WILL RECEIVE (IF APPLICABLE): _____

WHERE WILL MEDICATION BE ADMINISTERED? (CHECK ONE):

IS REQUEST FOR INITIAL OR CONTINUATION OF TREATMENT? _____

☐ Inpatient hospital ☐ Dr.'s Office or Clinic ☐ Dialysis Unit or Outpatient Hospital ☐ Other (please explain) _____

Billing Provider NPI: _____ **Rendering Provider NPI:** _____

Requests that do not include all pertinent information will experience a delay in the approval process.

_____ _____

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

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

Email this form (and any other relevant documentation or lab values) to:
HCPF_PharmacyPAD@state.co.us