COLORADO
Department of Health Care Policy & Financing

PRIOR AUTHORIZATION FORM

For pharmaceutical administered in outpatient 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) _____

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:
COLORADO MEDICAID PRIOR AUTHORIZATIONS
HCPF_PHARMACYPAD@STATE.CO.US