Request for Prior Authorization

All authorizations are pending valid eligibility.

hap EMPOWERED

Prescribing physician/provider:

Name: _____
First Last

Direct phone: _____

Please include the best phone number to reach you directly if we need to call you to complete our review of this request.

Fax: _____

Physician/provider specialty:

_____

Beneficiary:

Name: _____
First Last

Medicaid ID #: _____

Date of birth: _ _ – _ _ – _ _ _ _

Sex: ☐ Female ☐ Male

Name and title of person completing form (please print): _____

Drug name: Strength: Administration schedule: Length of therapy: Quantity requested:

a) _____

b) _____

c) _____

Patient's diagnosis for use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication: _____

2. Has the patient been seen by any other provider for this condition? ☐ Yes ☐ No
If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication:	Reason for failure:	Date:
_____	_____	_ _ – _ _ – _ _ _ _
_____	_____	_ _ – _ _ – _ _ _ _
_____	_____	_ _ – _ _ – _ _ _ _

4. Pertinent laboratory test or procedure (if applicable):

Procedure:	Findings:	Date:
_____	_____	_ _ – _ _ – _ _ _ _
_____	_____	_ _ – _ _ – _ _ _ _
_____	_____	_ _ – _ _ – _ _ _ _

5. Other information:

_____

_____

_____

Submit requests to:

FAX (313) 664-5460 • (313) 664-8940 option 3

HAP Empowered Medicaid • ATTN: Pharmacy • P.O. Box 2578 • Detroit, MI 48202

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