REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

Empowered

PRESCRIBING PHYSICIAN:

Name: _____
First Last

Direct Phone: (_ _ _) - _ _ _ - _ _ _ _

Fax : (_ _ _) - _ _ _ - _ _ _ _

Physician 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

HAP Empowered Medicaid
ATTN: Pharmacy
P.O. Box 2578
Detroit, MI 48202
(313) 664-8940 Option 3

HAP PA Comments
_____
_____
_____
_____
_____

DT REC:_____TIME REC:_GCN: a)
_____ b) _____ c) _____
EC: a)_____b)_____c)_____
Qty: a)_____b)_____c)_____
Appd: a)_____b)_____c)_____
R.Ph:_____DATE:_____
Entered by:_____DATE:_____
Auth # a)_____
b)_____
c)_____

HAP Empowered is a Medicaid health plan offered by HAP Midwest Health Plan, Inc. a wholly owned subsidiary of Health Alliance Plan (HAP). It is a Michigan nonprofit, taxable corporation.