Discharge Medication Request for Pharmacy Authorization

Please fill out the form below and return by fax to:
Fax: 1-833-615-0100 – ATTN: Pharmacy Department

Member First Name: _____ **Member Last Name:** _____

Member Medicaid Number: _____ **Member DOB:** Month ____ Day ____ Year_____

Member Discharged From (Hospital/Facility): _____

Facility Contact Person: _____ **Facility Phone Number:** _____

Prescription Information: Medication(s) will be dispensed up to a 30-day supply		
Rx Drug Name	**Drug Strength**	**Directions for Drug Use**
Prescriber Name:		
Prescriber NPI:		
Please fill out pharmacy information below (if known):		
Pharmacy Name:		
Pharmacy Location:		
Pharmacy Phone Number:		

Additional Notes or Instructions: _____

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