TennCare - Preferred Drug Program
Prior Authorization Request Fax Form
Fax Number: 866-434-5523

To ensure prompt response, please provide all information requested. Incomplete forms will be returned for additional information.

AUTHORIZED PRESCRIBER:
(Physician, dentist, PA, nurse practitioner, podiatrist)

Name: _____
First Last

Prescriber specialty: Pediatrics

DEA #: _____

Requested start date of Medication: __ __ - __ __- __ __ __ __

Person completing form: _____ UT Medical Group, Inc. _____
Name Title Date

Direct Phone #: (901) - 448 - 2000 Fax #: (901) - 572 - 3122 UT Medical Group, Inc., Primary Care Clinic

RECIPIENT:

Name:_____
First Last

Medicaid #: _____

Date of Birth: __ __ - __ __- __ __ __ __

PHARMACY NAME: Le Bonheur Outpatient Pharmacy **PHARMACY PHONE # (901) 572-3050**

Drug Name	Strength and Frequency	Quantity

1. Diagnosis for use of this medication? _____
2. Can a preferred medication be used by this patient? ☐ Yes ☐ No (If no please state reason below):

   Reason for use of Non-Preferred drug or agent requiring prior approval: _____

   _____

   _____

3. **Authorized Prescriber Signature (REQUIRED):**

_____ **Date:** _____

First Health Services use only

Reviewed Date: _ _ / _ _ / _ _ _ _ ☐ Approved ☐ Denied ☐ Prescriber Changed
Authorized timeframe: _ _ / _ _ / _ _ _ _ to _ _ / _ _ / _ _ _ _ ☐ **Returned for information on _____**

MAP RPh/Tech: _____ Comments:_____

Prescriber Response: _____ Date: _____

Mail requests to: First Health Services,
MAP Department, 14955 Heathrow Forest Parkway, Houston, TX 77032
Telephone 866-434-5524

PHONE NUMBER

Fax This Form to: 866-434-5523

The Tennessee Medicaid Preferred Drug List is available via the web at http://tennessee.fhsc.com