Washington State
Health Care Authority

Pharmacy Information Authorization

Org	1.	Authorization Type	2.
Client Information			
Name	3.	Client ID	4.
	5.	Reference Auth #	6.
Provider Information			
Pharmacy NPI #	7.	Pharmacy Fax #	8.
Prescriber NPI #	9.	Prescriber Specialty	10.
Prescriber Phone #	11.	Prescriber Fax #	12.
Date of Fill:	13.	Dispense as Written (Yes/No)	14.
Service Request Information			
Drug Name, Strength and Form: 15.		Actual per unit cost 16.	AWP per unit cost 17.
18. RX#		19. Wholesaler	

20. Code Qualifier	21. Product ID	22. Qty	23. Days Supply	24.	25. Directions for Use (SIG)	26. Prod Select Cd

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Patient Residence	29.		

30. Comments:

Please Fax this form and any supporting documents to 1-833-991-0704.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	**Org:** **(Required)**	Enter the corresponding number indicating whether this is a request for Authorization or a request for reimbursement Rate Adjustment for prescriptions ***NOT*** signed Dispense As Written: **512**: Pharmacy Authorization **522**: Pharmacy Rates
2	**Authorization Type:** **(Required)**	Indicate whether the request is an update to an existing authorization, or a new request for the client: **1**: New **2**: Update
3	**Name:** **(Required)**	Enter the last name, first name, and middle initial of the client you are requesting authorization for.
4	**Client ID: (Required)**	Enter the Client ID from ID card (9 numbers followed by WA.)
5		N/A – Leave blank.
6	**Reference Auth #:** **(Required for Updates)**	If requesting a change to or extension of an existing authorization, please enter the previous authorization number in this field.
7	**Pharmacy NPI #:** **(Required)**	The unique 10 digit numeric identification number that has been assigned to the Pharmacy by CMS.
8	**Pharmacy Fax#: (Required)**	The Pharmacy's fax number, excluding dashes or spaces. (123)123-1234 would be entered as 1231231234.
9	**Prescriber NPI #:** **(Required)**	The unique 10 digit numeric identification number that has been assigned to the Prescriber by CMS.
10	**Prescriber Specialty:**	The specialty practice of the prescriber.
11	**Prescriber Phone #: (Required)**	The prescribing provider's phone number, excluding dashes or spaces. (123)123-1234 would be entered as 1231231234.
12	**Prescriber Fax#: (Required)**	The prescribing provider's fax number, excluding dashes or spaces. (123)123-1234 would be entered as 1231231234.
13	**Date of Fill:** **(Required)**	If the authorization request is for a prescription that has already been dispensed to the client, enter date of fill. Otherwise, enter date of authorization request submission.
14	**Dispense as Written: (Yes/No)**	Enter **YES** if the prescription was signed 'Dispense as Written'. Enter **NO** if the prescription was signed 'Substitution Permitted'.
15	**Drug Name, Strength and Form: (Required)**	The name of the drug, the strength, and the form requested for dispense to the client.
16	**Actual per unit cost: (Required for Rate Adjustments)**	Actual Acquisition Cost per unit paid by the pharmacy.
17	**AWP per unit cost: (Required for Rate Adjustments)**	The Average Wholesale Price per unit listed by your wholesaler.
18	**RX#: (Required)**	The unique number assigned to the prescription.
19	**Wholesaler:** **(Required for Rate Adjustments)**	The name of the wholesaler the medication was purchased from.
20	**Code Qualifier:** **(Required)**	Enter **03** for National Drug Code (requests for authorization of products by UPC code are not accepted)

21	**Product ID:** **(Required)**	The National Drug Code of the product being requested, in 11-digit format, with leading zeros, excluding dashes (e.g. NDC 12345-12-1 must be entered as 12345001201). Only one NDC can be requested per form. Please disregard additional lines available on the form (reserved for later use).
22	**Quantity:** **(Required)**	The quantity of product requested for this fill.
23	**Days Supply:** **(Required)**	The minimum number of days that the requested quantity would be expected to last according to the prescribed directions for use.
24	**N/A**	Leave blank.
25	**Directions for Use (SIG):** **(Required)**	The prescribed directions for use for this fill.
26	**Prod Select Code:** **(Required if the prescription is signed Dispense as Written)**	Enter **1** f the prescription is signed Dispense As Written. Otherwise leave blank.
27	**Diagnosis Code:**	If known, enter appropriate ICD-10 diagnosis code for condition being treated.
28	**Diagnosis name:**	Short description of the diagnosis the requested product will be used to treat.
29	**Patient Residence:**	Enter the corresponding code for the client's living arrangement: **01 –** Client does not reside in a skilled nursing facility. **02 –** Client resides in a skilled nursing facility. **11 –** Client is part of a hospice program, but the requested medication is not related to the client's terminal illness.
30	**Comments:**	Enter any additional information necessary to explain the medical necessity for the requested fill.

Note: A confirmation fax will be sent to you if your fax number can be identified by caller ID. The receiving fax must recognize the number the fax has been sent from.