



Georgia Watch Form
Fee-for-Service Medicaid &
PeachCare for Kids

Prior Authorization
 Claims Processing
 Phone: (866) 525-5827
 Fax: (888) 491-9742
 P.O. Box 3214
 Lisle, IL 60532-8214

FAX TO: 888-491-9742

Today's Date _____

Note: All of the following requests for information must be answered completely, correctly, and legibly, otherwise the authorization process will be delayed.

First, Middle, Last
 Member Full Name _____

Member ID# _____ Member DOB _____ / _____ / _____

Medication/Strength Requested _____ Dosage Form _____ Quantity _____

Diagnosis _____ Directions _____

Generic products tried? *(Circle one)* NO or YES *If yes, list the names of the manufacturers of generic products tried.*

1. _____ 2. _____ 3. _____

What was the patient's response to each generic product? *(A response description MUST be given.)*

<u>Product Name</u>	<u>Response</u>
1. <i>Response description:</i>	<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other
2. <i>Response description:</i>	<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other
3. <i>Response description:</i>	<input type="checkbox"/> Subtherapeutic Response <input type="checkbox"/> Allergy <input type="checkbox"/> Side Effect <input type="checkbox"/> Other

Please print legibly
 Physician's Name _____

Physician's Signature _____

Required
 NPI Number _____

Physician Address _____

Physician Phone _____ Physician Fax _____

Medical Office Contact _____ Signature _____

Any additional information pertaining to this drug request should be included and attached to this form.

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