PRINT FORM SUBMIT FORM

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Providers' Administered Drug List (PADL) Review Request Form

The request to consider coverage of additional injectables or changes to existing injectable drugs will be completed in the order received. The goal is to complete the review and respond to requests within 30 days of receipt of the completed form. For detailed information regarding the PADL policy refer to Part II Policy and Procedure Manual for the PADL. All Medicaid policy manuals for the Georgia Department of Community Health (DCH) are accessible online at www.mmis.georgia.gov; click on the "Provider Information" tab; then the "Medicaid Provider Manuals" link.

Request Date: _____

REQUESTOR CONTACT INFORMATION

Provider Name & Number: _____

Name of office Contact: _____

Practice/Company Name: _____

Address: _____ **City, State Zip** _____

Phone: _____ **FAX:** _____ **Email:** _____

REQUEST

Request consideration to: ☐ Open new injectable drug ☐ Change or add new indication(s) to already approved drug

Chemical Name: _____ **Brand Name:** _____

HCPCS/CPT Code(s): _____ **Dose/Unit:** _____

NDC(S): _____ **AWP/Unit:** _____

Does the manufacturer offer rebates on the drug at this time? ☐ **Yes** ☐ **No**

Approved Indication(s): _____ **ICD-10 Code(s)** _____

FDA Approval Date: _____ **If not FDA approved, date application submitted?** _____

Is there a specific Medicaid eligible patient pending this determination? ☐ **Yes** ☐ **No**

If yes, please indicate patient's name and Medicaid ID# _____

Briefly summarize your request in the space provided below and attach any supporting documentation you wish to be considered:

_____

Submit completed request electronically to: injectable.rx@dch.ga.gov

for receipt by:
Medical Policy Unit/PADL Review
Georgia Department of Community Health

DCH USE ONLY

PBM Consulted (Y/N)	
Approved/Denied	
Maximum Allowable	
Maximum Units	
PA Required (Y/N)	
Effective Date	
Requestor Notified (Y/N)	
Date Review Completed	

Comments: